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Manitoba Medical Review

Vol. 33 JANUARY, 1953 No. 1

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The Manitoba Medical Review

Vol. 33 JANUARY, 1953 No. 1

Opthalmology

Bilateral Blindness of Sudden Onset: Principal Etiologies

Frank B. Walsh, M.D.

Your invitation to me to address the Manitoba Medical Society is an honor which I appreciate deeply. It is now more than thirty years since I graduated from Manitoba in the class of '21. Throughout that time I have become increasingly aware of my indebtedness to my teachers in this University. I am happy today to have seen and talked with several of them again and to know that others are still active in their work. In retrospect it becomes clear that the extracurricular activities of student days are only slightly less important than the scientific training. Many of my friends, some here present, helped make those activities a very pleasant memory. I am saddened to recall the many fine fellows who have passed on.

The choice of a suitable subject has given me concern in that I realize I am addressing a group whose individual interests are varied. Your Committee has been kind in allowing me to select a topic, and I have chosen to talk to you on "Bilateral Blindness of Sudden Onset." Such cases are encountered at all ages. A minority represent a surgical emergency and another minority represent acute problems in nonsurgical therapy. In all the diagnosis is vital and the prognosis is an urgent consideration. I cannot attempt completeness but propose to transmit to you an outline of my experiences with such cases. Therapy is considered briefly in a few instances. Injuries to the eyes and visual pathways are not commented upon and purely ocular affections such as cataract, retinal detachment and glaucoma do not qualify for consideration under the title.

Bilateral Blindness of Sudden Onset: Principal Etiologies.

Demyelinizing Diseases: Encephalomyelitis-measles; chicken-pox; mumps; vaccinia; pertussis; neuromyelitis optica.

Poisons: Methyl alcohol; lead; quinine; nitrous oxide.

Toxic Affections: Eclampsia; uremia.

Cerebrovascular Accidents: bilateral homonymous hemianopsia.

Air Embolism.

Hemorrhage: Blood Transfusion Reactions.

Postepilepsy.

Intracranial Tumors.

Hysteria.

Measles Encephalomyelitis

The encephalomyelitides which complicate the infectious diseases of childhood are essentially similar as regards symptoms and signs. Only the encephalomyelitis of measles is described here briefly.

It has been estimated that in slightly less than 0.5 per cent of cases of measles there is development of encephalomyelitis. Such cases may be divided into six groups (Ford) according to their symptomatology: (1) diffuse cerebral involvement of short duration; (2) multiple focal or diffuse lesions of the central nervous system; (3) cases with signs of a single focal lesion; (4) cerebellar syndromes; (5) spinal syndromes; (6) cases with optic neuritis. Comment is made only on groups 1, 2 and 6.

The essential pathology in the central nervous system is perivascular demyelinization with sparing of axis cylinders.

(1) In this group there are more cases than in any other. From the fourth to the fifth day after the onset to as long as ten days there is sudden elevation of temperature, drowsiness, headaches and vomiting; there may be dilatation of the pupils and Kernig's sign may be present. The spinal fluid is under increased pressure, contains an excess of cells (20-200 per cu. mm.); total globulin and protein are increased. In spite of the alarming symptoms complete recovery occurs within a few days.

(2) When there are signs of multiple involvement the picture is essentially that outlined above but in addition there is likely to be optic neuritis, Cheyne Stokes type of respirations, retention of urine and coma. Within a week or ten days there may be development of monoplegia, hemiplegia or ataxia. Subsequently tremors, choretic syndrome or athetosis may appear.

(6) In measles encephalomyelitis optic neuritis is frequently present. Usually it occurs as part of a multiple involvement of the nervous system but it may be an isolated manifestation. Frequently the ophthalmoscopic picture establishes the diagnosis but in some instances of retrobulbar neuritis the optic fundi remain normal in appearance for as long as three weeks when pallor of the discs and some narrowing of the retinal arteries appear. The loss of vision varies within wide limits. Total bilateral loss is unusual but it does occur. It is important to know that measles encephalomyelitis

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is a cause of partial bilateral blindness. In the absence of any history suggesting encephalomyelitis not infrequently in such cases hysteria is an erroneous diagnosis. In all cases of blindness, either total or partial, arising from measles encephalomyelitis the prognosis for return of vision to normal is excellent.

Death occurs in approximately 10 per cent of cases. There is a pronounced tendency toward recovery from all nervous system involvements although in severe cases such improvement may be slow in its development.

German measles is rarely productive of optic neuritis. Otherwise the nervous system involvement is essentially similar to that outlined above.

Chickenpox encephalomyelitis may be associated with optic neuritis producing complete loss of vision. In one case that comes to mind the loss of vision was total within a few hours. Three weeks later the acuity was 20/15 for each eye; the optic nerves were white but otherwise the fundi appeared normal.

Vaccinia encephalomyelitis is similar in its manifestations to that seen with measles. No cases have been observed in children less than a year of age. This is a good reason to advocate vaccination during infancy.

The encephalomyelitis which is associated with mumps occurs within three to four weeks after the onset of the disease. The prognosis for return of normal vision is not as good as with measles. There is a permanent reduction of visual acuity in about half such cases.

Pertussis is associated with loss of vision under two circumstances. Transient blindness as part of the paroxysms is not uncommon. Blindness as a result of pertussis is exceedingly infrequent, in fact pertussis rarely produces encephalomyelitis. Such blindness has been reported always with complete recovery.

Neuromyelitis Optica

This remarkable affection, characterized by blindness and paraplegia, occurs infrequently. From 1930 to 1940 we saw many such cases but in the past decade have observed only an occasional example.

Neuromyelitis optica is characterized by widespread demelinization which principally affects the white matter of the brain, the optic nerves, and the spinal cord. Usually the cerebellum is spared. During the active stage of the disease the spinal fluid usually contains 20-50 or more lymphocytes per cu. mm.

In many instances vision is first lost in one eye and then in the other within hours or a day or two. The loss of vision is followed within days or weeks by paraplegia. In a minority of cases, in our experience, paraplegia develops before there is loss of vision. Incomplete syndromes are encountered: blindness or paraplegia are seen as isolated involvements.

The course of the disease is variable. Usually within one or more weeks the visual acuity returns to normal or near normal but in a minority of cases there is severe permanent reduction in visual acuity and we have seen permanent blindness. The paraplegia shows a distinct tendency toward recovery. Either the optic neuritis or the paraplegia may recur. Approximately 10 per cent of our cases have been terminated by death.

Misdiagnosis during the early stages is the rule. The optic discs are invariably swollen as a result of the optic neuritis. Because of the edema of the optic discs it is suspected that there is an intracranial tumor responsible for the blindness. It is important to know that with rare exceptions (which I shall mention subsequently) an overnight loss of vision should guide us away from a diagnosis of cerebral tumor. When paraplegia is the presenting sign tumor of the cord may be suspected. Here again it is unlikely that neoplastic cord involvement would develop with such rapidity.

The treatment is symptomatic for the paraplegia. We have not had experience with cortisone or ACTH in the treatment of this disease. I would venture an opinion that it is without value.

Methyl Alcohol (Wood Alcohol, Columbian Spirits) Poisoning

Poisoning with this substance occurs sporadically. Among troops during World War II it was a frequent cause of blindness. Individuals who indulge regularly in methyl alcohol, commonly known as smoke-hounds, are encountered less frequently than during the 1930's but some are still around. Although they become deteriorated mentally, morally and physically it is remarkable that they rarely suffer loss of vision. Undoubtedly susceptibility to methyl alcohol poisoning varies widely and blindness occurs in individuals who have not consumed the substance previously.

Wood alcohol poisoning produces an increased viscosity of the blood and an increase in the amount of cerebrospinal fluid. The cerebral ganglion cells are shrunken and this explains cortical atrophy. Much has been written about the ocular pathology without complete agreement having been obtained. Whether or not the blindness associated with this poisoning is due to a selective involvement of the retina or whether the retina is unable to withstand the edema which also is found in the cerebral tissues remains unsolved. It seems unlikely that the edema in itself is of particular significance as regards blindness because even more pronounced edema seen in eclamptics does not presage loss of vision.

The amount of methyl alcohol necessary to produce poisoning and blindness varies, in fact various types of methyl alcohol have different degrees of toxicity so that it has been suggested it

is impurities in the alcohol that are principally responsible for the toxic effects. Reports are available that as little as a teaspoonful has caused blindness.

We may divide individuals suffering from this poisoning into three groups from the standpoint of severity. (1) In this group there is mild poisoning which is characterized by blurred vision, nausea, headaches and vomiting. (2) Moderately severe poisoning results in defective vision particularly for distant objects, cramp, vomiting, hiccoughs, dyspnea, drowsiness in about that order. (3) In severe cases there is coma, cyanosis particularly affecting the upper part of the chest and face. The skin is clammy, the pupils are dilated and fixed, respiration is labored, the pulse is thready and there are decerebrate convulsions.

Blurring of vision is an early sign of poisoning; such blurring associated with visual loss comes on within a few hours at the most. It has been stated that pronounced loss of vision or complete blindness during the early hours of poisoning has a serious prognostic import. This is true only if the other evidences of poisoning are profound. Even total blindness which comes on within a short time after the alcohol has been consumed does not make the prognosis poor for life or for return of vision. What is to be feared as regards vision is a secondary loss which often comes on weeks after the initial loss of vision has been recovered from. In those cases in which there is a late secondary loss of vision the outlook for any recovery is hopeless; the defect progresses and such unfortunate individuals invariably become totally blind. With the ophthalmoscope the fundi may remain normal through the early stages in cases where there is loss of vision but usually in them there is retinal edema and some narrowing of the retinal arteries. Pallor of the disc does not usually appear until several weeks have passed and it is then that the possibility of secondary failure is present.

As regards treatment of methyl alcohol poisoning some real advances have been made. Roe has shown conclusively that acidosis is the real danger. Methyl alcohol is excreted slowly and is changed to formic acid in the urinary tract. Plenteous amounts of fluid, intravenous bicarbonate of soda injections and blood transfusions are essential in the treatment. When the acidosis has been controlled the patient's life has been saved. If there is initial loss of vision it can confidently be anticipated that it will improve but when there is then a secondary visual loss the ultimate result is total blindness.

Lead Poisoning

Lead poisoning occurs in adults as an occupational hazard. It is seen most frequently in children through accidental ingestion of lead. In Baltimore during 1951 there were 77 cases of lead poisoning in children and there were 9 fatalities. Children are more susceptible to such poisoning than are adults. Frequently the diagnosis is delayed because it has not been considered. It should be suspected in all cases in which there is loss of vision whether or not there are visible changes in the optic fundi.

Poisoning with lead produces swelling of the cerebral tissues, hemorrhages and gliosis. The swelling of the brain may be sufficient to produce herniation of the medulla into the foramen magnum. Lead produces polyneuritis and rarely muscular atrophy.

Lead enters the body through the alimentary tract, by inhalation, and through the skin. Lead carbonate is soluble in the stomach juices. It is transported in the blood as a colloidal phosphate. Lead is deposited in all organs but particularly in the bones and liver. It is eliminated chiefly in the urine and feces. When the acute stage of lead poisoning has passed reintoxication may develop as a result of liberation of lead which has been stored in the bones.

Certain tests are important in the diagnosis. There is stippling of red blood cells. The blood lead is elevated. Normal readings range from 0.01 to 0.03 mgm. per cent. Symptoms of lead intoxication usually appear when the blood lead reaches 0.1 mgm. per cent and when it has reached 0.3 mgm. per cent there is extreme danger. The urine, feces, hair and nails contain lead. Roentgenograms show lead at the growing ends of the long bones. Such findings in the x-ray raise interesting possibilities in differential diagnosis because a similar appearance may be the result of hypervitaminosis D, healing rickets, and phosphorus poisoning. The spinal fluid contains excess globulin and some increase in cells whereas in the chronic lead encephalopathy there is only an increase in protein.

The general symptoms are headaches, muscular weakness, lead-line on the gums (not reliable because often absent), colic, constipation and rarely jaundice and albuminuria. In children, where a single consumption of lead may result in poisoning, convulsions are an early symptom; such convulsions are likely to be followed by coma and death. In acute poisoning cranial nerve palsies and hemiplegia are rarely seen. Recovery from acute lead encephalopathy occurs not infrequently but some residual mental or visual defect is the rule. Ocular signs which are considered subsequently are commonly present.

Chronic lead poisoning produces a chronic encephalopathy which usually is difficult to evaluate. Optic atrophy, mental changes and convulsive attacks may be observed as the result of such chronic intoxication.

The ocular signs of lead poisoning are important particularly in the acute cases. Paralyses of the extraocular muscles have occurred frequently in our cases, but in most instances the sixth nerves have been affected and possibly the palsies have been due to increased intracranial pressure. Papilledema has been present in a high percentage of our cases seen in children. Pupillary changes are rarely observed. Optic neuritis, according to most observers, is more frequent than papilledema but this has not been our experience. We have seen many cases of pronounced papilledema in children; in these there has been pronounced increase in intracranial pressure.

In some cases of acute poisoning there is sudden bilateral loss of vision. In these cases there is generalized grayness of the retinae resembling that seen as the result of an embolus obstructing the central retinal artery; the arteries are narrow; it would seem unquestionable that retinal arterial spasm is responsible for the fundus picture. Recovery of vision may be anticipated with reasonable certainty if the fundus appearance does not persist more than a few days. In other cases there is gradual decrease in visual acuity; the optic discs are hyperemic, the retina is edematous and there is a central scotoma in the visual fields. In such instances the prognosis for return of vision is uncertain. There may be development of a star-figure at the macula and the fundus appearance is that seen in albuminuric retinitis. In these and in all cases where pronounced fundus changes tend to persist the prognosis for return of vision to normal levels cannot be considered as good.

In acute lead encephalopathy convulsions may be difficult to control and a general anaesthetic may be required. In some cases where there is a great increase in intracranial pressure decompression may be necessary. Deleading may be accomplished by using parathyroid extract or potassium iodide. There are two schools of thought regarding the advisability of deleading. One group believes that since lead is slowly liberated from the bones it is best not to hurry the natural cure and run the risk of producing reintoxication. The other viewpoint is that deleading should be activated under careful control. I do not have experience with deleading but have observed "natural cure" to have been satisfactory in a number of cases.

Quinine Amblyopia

Other than in the treatment of malaria quinine is not widely used and now that atabrine has been found generally effective and safer in the treatment of malaria quinine amblyopia may disappear from differential diagnosis. Although not pertinent to the title of this paper mention may be made in passing of the beneficial effects of quinine administration in cases of myotonic dystrophy and of its harmful effects in myasthenia gravis.

Quinine amblyopia is rarely observed in civilian practice. It is characterized by loss of vision which varies from case to case. In some instances there is total bilateral blindness after a single ingestion of a large amount of quinine, in others after a cumulative effect has been obtained. The loss of vision is sudden, almost apoplectic. The amaurosis may persist for days or even for weeks but in all cases ultimately there is some recovery of visual acuity.

The ophthalmoscopic picture in pronounced cases of amblyopia is of interest. At the onset the fundi resemble what is seen with central retinal obstruction. The discs are blurred, the fundi generally are gray in color and there is some narrowing of the retinal arteries. There may be a reddish area about the fovea. As time passes a remarkable paradox develops: the discs become increasingly pale, the vessels continue to shrink but the vision improves. Ultimately in severe cases the vessels cannot be recognized as such beyond the midfundus and the optic discs are totally white. The visual fields are concentrically contracted. Central vision may be 20/15.

Nitrous Oxide Anaesthesia Encephalopathy

It is generally well known that chloroform when used as an anaesthetic occasionally produces delayed poisoning evidenced largely by kidney and liver change. It is not widely known that nitrous oxide may produce profound and irreversible changes in the brain.

The cerebral changes resulting from nitrous oxide poisoning are similar to those seen in individuals who have died as a result of chloroform poisoning or, what is more uncommon, after ether anaesthesia. There is extensive degeneration of cortical cells, foamy areas of vacuolation, and rarefaction and disintegration of the cortex. There may be signs of hemorrhagic encephalitis (Courville).

In nitrous oxide poisoning there usually is a history that the anaesthetic has not been "smooth" but this is not always the case. Usually the first indication that anaesthetic poisoning has occurred is prolonged unconsciousness which in some instances has persisted for as long as several days. During this period convulsions occur in a majority of cases. When consciousness has been regained it is obvious that the cerebral cortex has suffered damage. Blindness, abnormalities of ocular movement, aphasia, ataxia and apraxia are prominent signs of such damage. Over a period of months there is a tendency toward improvement but complete recovery is the exception and not the rule. We have observed permanent blindness.

When presented with a case of prolonged unconsciousness following anaesthesia when nitrous oxide or some other anaesthetic has been used the first question which arises is whether or not the

patient has suffered a cerebral vascular accident. Convulsions occurring during the stage of unconsciousness suggest anaesthetic poisoning. If the physical signs point to unilateral hemispheric or brain stem involvement it is most unlikely that the anaesthetic is responsible. A frank hemiplegia or hemianopsia speaks for cerebral vascular accident rather than for anaesthetic poisoning.

Eclampsia

The blindness which develops in eclamptics may be pronounced but it is never complete according to my experience. The loss of vision may be unequal in the two eyes but it is present in some degree in both. The loss of vision is maintained at its extreme level for not more than 12 hours in most instances. Hemianopsia has been reported in association with eclampsia but in such cases where vascular hypertension has been present before pregnancy the vascular accident is not necessarily due to the eclampsia. With eclampsia the fundus picture varies within wide limits. The classical features are retinal edema with retinal arterial narrowing and spasm; retinal hemorrhages may be present. Detachment of the retina often bilateral is not uncommon in these cases. In many instances the retinal detachments disappear spontaneously.

For many years I have been interested in the constantly increasing use of the ophthalmoscope in the Obstetrical Department of the Johns Hopkins Hospital. In women who exhibit evidences of vascular hypertension before pregnancy, in those who have had eclampsia previously, and in pre-eclamptics eyeground examinations are made frequently. The woman who has suffered from vascular hypertension and who develops pre-eclampsia is a worse risk than the woman without a previous vascular hypertension. In many critical cases the ophthalmoscopic findings are the deciding factor as to whether or not the pregnancy must be terminated.

Uremia

Generally speaking the patient in uremia exhibits optic fundi with plentiful evidences of retinal arteriosclerosis, retinal hemorrhages and exudates. Often there is a star-shaped figure in the macula. However, abnormalities of the optic fundi may be entirely absent in individuals who die from uremia.

Rather often individuals suffering from uremia complain of defective vision and in some instances they become quite blind. The pupils continue to react to light in a majority of cases. This suggests that the loss of vision is due to interference with function at the cortical level. With recovery from the uremia the visual acuity returns to its former level providing that hemorrhage or other change in the maculae does not make such improvement an impossibility. We have seen an individual with uremic amaurosis recover vision to a considerable degree when laboratory tests showed only slight reduction in the blood urea level and slight improvement in the C02 combining power; the vision fluctuated until death occurred and at no time could the transient improvements in laboratory findings be reflected clinically other than in the visual acuity.

Bilateral Homonymous Hemianopsia

This accurately descriptive title has been utilized only rarely during the past thirty years. In actual practice bilateral homonymous hemianopsia is not an extreme rarity. If we recall that in many cases of hemiplegia there is an associated loss of vision on the hemiplegic side (hemianopsia), the term bilateral homonymous hemianopsia is readily understandable. Both half-fields of vision are blotted out and the patient is blind. What is truly remarkable about bilateral homonymous hemianopsia is that it results from a selective involvement of the calcarine arteries which supply the visual cortices. In many of these patients the only abnormal neurologic sign of significance is the loss of vision. In some there are signs suggesting involvement of the basal ganglia, and in others there are evidences of bilateral hemiplegia.

It has been our experience that classical cases of bilateral homonymous hemianopsia are characterized by simultaneous loss of both visual half-fields. In a minority there is first a hemianopsia, with or without an associated hemiplegia, and later the development of an opposite-sided hemianopsia which leaves the patient blind or at most retaining only a small central field. In such cases as may properly be termed bilaterial homonymous hemianopsia the pupils continue to react to light and the optic fundi excepting for evidences of arteriosclerosis are likely to be normal. Total blindness persists only in a small percentage of cases. Usually within a few days at most there is clearing of the central field so that the vision on tests may be normal but the central field is so small (5-8 degrees) that the patient remains severely handicapped. When improvement to the degree mentioned has developed some further widening of the fields can be anticipated in a majority of cases.

This affection has been described here because it occurs not infrequently as part of a hypertensive crisis. Because blindness or near-blindness may be the only significant symptom there is a danger of the misdiagnosis of hysteria.

Air Embolism

Air embolism originates from the introduction of air into the blood stream. It may occur as the result of injuries or operations on the chest wall, performance of artificial pneumothorax or pneumoperitoneum, wounds of the jugular vein or assumption of the knee-chest position by women

soon after confinement. Air embolization has followed catheterization of the right side of the heart.

The mechanism underlying the development of air embolism is not entirely clear. There must be (1) a wounded vein; (2) available air; (3) either positive or negative pressure accounting for the continued entrance of air into the open vein.

Air embolism produces small areas of necrosis and hemorrhage in the brain.

The symptoms appear in most instances immediately after the air has entered the vein and when the symptoms seem delayed it is probable that there has been delay in the air gaining access to the vein. There is complaint of pain in the head, nausea, vomiting and in some instances blindness. The pulse is rapid, breathing shallow and labored. Convulsions develop and consciousness is lost in severe cases. Hemiplegia, cranial nerve palsies and mental aberrations are commonly present.

Sudden death from air embolism occurs in a minority of cases. Death is due to cardiac failure. It is not generally known that the simple expedient of turning the patient on his left side may suffice to relieve the situation. This position tends to relieve the right ventricle and allow the air to pass into the lungs. (See Musgrove and MacQuigg, J.A.M.A., 1952, 150; 28).

Blindness is the outstanding ocular involvement. The optic fundi usually are normal although occasionaly a retinal hemorrhage may be observed. Air is not seen in the retinal vessels because its passage through these vessels is very rapid indeed and examinations of the fundi are made after there is any possibility of detecting air bubbles.

What has seemed to be the most interesting single feature of air embolism is the prognosis. If after the onset of symptoms the patient lives for an hour the prognosis is relatively good. If life is maintained for several hours survival is a certainty. Neurologic signs may be multiple but there is a decided tendency for them to disappear. If blindness occurs and the patient survives return of vision and visual fields to normal can be predicted with confidence.

Hemorrhage

Blindness occasionally follows hemorrhage; actually repeated small hemorrhages are more likely to produce blindness than a single large hemorrhage. In a minority of cases (25 per cent) the onset of defective vision is during or immediately after the hemorrhage has occurred; in the remaining cases the visual defect appears from three to seven days and rarely as late as three weeks after the hemorrhage. In 10 per cent of cases the blindness is unilateral.

In moderately severe and severe cases of loss of vision the retinae become gray and there is attenuation of the arteries. Exudates and swelling of the optic discs develop.

The prognosis for return of vision is uncertain. In my limited experience with such cases recovery has been the rule, but observers have stated that recovery occurs in some degree in about fifty per cent of cases.

Blood transfusion is proper treatment but it does not ensure recovery of vision.

Blood Transfusion Reactions

There are two types of blood transfusion reaction: (1) the common febrile or anaphylactic reaction which is not serious and (2) the hemolytic reaction which usually, but not always, is due to faulty blood grouping. It is in this latter group that dangerous reactions develop; when such reactions develop hours after the transfusion has been given they are uremic in origin.

Following blood transfusions retinal hemorrhages are seen rather often if they are carefully searched for. In individuals who require transfusion retinal hemorrhages are not infrequently present, often on a basis of anemia, and consequently before any transfusion is given the optic fundi should be carefully examined. Optic neuritis and spasm of the retinal arteries has followed the transfusion of blood. My experience with blood transfusion producing blindness is limited to a single case of an individual who suffered from sickle-cell anemia (a disease which is seen in Negroes and consequently non-existent or rare in Manitoba). In my patient vision remained at light perception a year after the transfusion had been given.

Post-Epileptic Amaurosis

Particularly in children there may be blindness following a series of convulsions. In such cases the problem is whether or not the convulsions have been responsible for the blindness. When after a series of convulsions there is blindness followed by recovery of vision and this sequence is repeated then it would seem reasonable to assume that the convulsions have been responsible for the loss of vision. In some reported cases such amaurosis may be associated with aphasia and/or hemiplegia. In a majority of cases of blindness following epilepsy the optic fundi have remained normal in appearance. This suggests that the blindness has been due to changes at the cortical level since otherwise there would have been late development of pallor of the optic discs.

We have seen recovery of vision following epilepsy delayed for as long as several weeks.

Intracranial Tumors

An overnight or similar rapid loss of vision as a general rule eliminates intracranial tumor as the etiologic factor. Such rapid loss of vision ordinarily speaks for optic neuritis as has been

observed with neuromyelitis optica and the encephalomyelitides. It is important to know that rapid loss of vision in one or in both eyes may be the result of hemorrhage into a pituitary adenoma as I have observed on three occasions. Also rapid loss of vision may develop in individuals who harbor a craniopharyngioma or pinealoma, but in such cases where sudden swelling, and not hemorrhage, is responsible the visual loss is not as apoplectic as with hemorrhage into pituitary tumor.

Two cases illustrating hemorrhage into a pituitary adenoma are now cited briefly in order to clarify the diagnostic features.

A man, 55 years of age, exhibited evidences of acromegaly for many years. He complained of severe headaches for a day or two and then suddenly lost practically all vision in both eyes. There were no recognizable ophthalmoscopic abnormalities. However, in addition to partial blindness there was inability to move the eyes in any direction (total ophthalmoplegia). It was predicated that this man had suffered a hemorrhage into a pituitary adenoma and that the ophthalmoplegia was due to pressure in or on the cavernous sinuses. Operation was performed and complete recovery of vision and ability to move the eyes followed. The second case was that of a middle-aged man who suffered a severe headache during one night and in the morning was able only to distinguish light and was unable to move his eyes in any direction. X-rays revealed enlargement of the sella turcica and erosion of its floor. The patient refused operation but ten days later asked that it be performed. Today excepting for total blindness he seems entirely well. In a third case the symptomatology was precisely that already described excepting that loss of vision and ophthalmoplegia was limited to one eye; recovery followed operation. From these cases it becomes obvious that when there is headache associated with sudden loss of vision, unilateral or bi-lateral, and when to this there is added an inability to move the eyes, intracranial tumor with hemorrhage into it becomes a probability.

Diagnosis in children is often extremely difficult. I shall cite such a case in which tumor was responsible for rapid loss of vision. A child, age 7 years, had enjoyed good health excepting for some unexplained fever from which recovery had been made a month before the episode which is now recounted. The child went to school in the morning seemingly perfectly well. In the early afternoon she complained to the teacher that she was unable to see the blackboard. Her parents were called to take her home. They were convinced that the child was truthful as regards her visual incapacity but not so the pediatrician. He concluded that since the onset of blindness was acute and unassociated with other symptoms, and the optic fundi appeared normal, the proper diagnosis was hysteria. This diagnosis seemed reasonable to the Staff of the hospital to which the child was admitted. When the child was brought to my clinic the pupils failed to react to light. It was reasonably established that atropine or other cycloplegic had not been used. A spinal air injection revealed a deformity of the third ventricle. A craniopharyngioma was found at operation. The child died on the following day.

As a digression I wish to remark briefly on a peculiar sequence of symptoms in a child since it emphasizes a point in the diagnosis of cerebral tumor which I have not seen in the literature. A girl, two years of age, was brought for examination because her physician had found her to be blind. There was no history of recent illness. When he saw the child there was no question regarding the blindness. The optic fundi appeared normal. X-rays were declared to show nothing remarkable. We decided that since there probably existed a bilateral retrobulbar optic neuritis it might be wise to desist from further examinations for a time at least. Three weeks after the child was discharged from observation the referring physician called me to say that the child's vision seemed quite normal. I congratulated myself on the handling of the case and pointed with some satisfaction to having eliminated air injection as part of the study. A year later I was shocked when the youngster was brought to my clinic. She had developed a huge hydrocephalus and was totally blind. Operation revealed a craniopharyngioma. The vital lesson from this case is that in rare instances pronounced recovery of vision does not eliminate cerebral tumor as the etiologic factor for the initial loss of vision.

Conclusion

An effort has been made to describe briefly the principal etiologic factors responsible for sudden bilateral loss of vision. Such cases although not of every day occurrence are vitally important to all practitioners.

Urology

The Treatment of Ureteral Calculus

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The prevalence, the diagnostic uncertainties and the treatment problems of ureteral calculus make the subject of practical interest to almost all of us. One to three per cent of all hospital admissions are for urinary calculi and most of these stones occur within the ureter. Ureteral colic is most distressing and disabling and is, of course, one of the common emergencies of medical practice. We are concerned, in this presentation, with calculi within the ureteral areas, particularly the lower ureter and the scope of the discussion is limited to the therapeutic aspects of the condition.

The treatment of the general subject of urolithiasis can be divided into five headings, one or more of the indicated methods being applicable to each case.

1. Preventative treatment.
2. Palliative treatment.
3. Medical treatment.
4. Surgical treatment including endoscopic manipulative measures.
5. Follow-up treatment.

Preventative Therapy

Preventative therapy demands a consideration of the little understood etiological factors involved in stone formation. Incomplete knowledge of the causative pathogenesis of lithiasis should not, however, deter us from attempting to determine the antecedent factors in the specific case. Adequate fluid intake and dietary balance should be adjusted in each individual case. Problems of infection, vitamin deficiency, mineral imbalance, high calcium intake, parathyroid disease and recumbency should be investigated and controlled. Preventative therapy, of course, is of extreme importance in the unfortunate individual who is a "stone former." Thorough investigation and control are essential to avoid serious renal damage and repeated sepsis.

Palliative Treatment

Palliation is, of course, imperative to control pain until a diagnosis and assessment of the case have been made. Morphine in large doses is often necessary to render the patient comfortable. A word may be interpolated here about the numerous commercial preparations periodically hailed as the most efficient and revolutionary agents for relaxing smooth muscle and promoting the passage of ureteral calculi with the prompt relief of symptoms. As one who has repeatedly tried many of them out and thereby chased the "will o' the wisp," I am convinced that nothing superior for the relief of ureteric colic than opium derivatives and atropine has yet been presented.

The great majority of ureteral calculi pass spontaneously and it is difficult to assess the effectiveness of any particular palliative measure. Many calculi are minute, some because of their chemical and physical structure non-radio-opaque. Under these circumstances they may defy accurate diagnosis by radiological methods alone.

Adequate fluid and electrolytic balance are essential as there may be considerable fluid loss through vomiting and sweating.

Medical Treatment

Medical treatment offers little in the treatment of stone in the ureter. The dissolution of calculi within the body has been described "as still the sideshow." Solution "G" and its modification Solution "M" have accomplished a diminution of the size of calculi in vivio but at the present time there are no practical methods of applying them in the treatment of stones in the ureter. Mention should be made of chelating agents such as versene, calsol and calgol which have the power of rendering calcium salts water soluble. Basojel, by diminishing phosphorus output, has its uses. The use of dissolvents is, of course, limited, at the best, to the treatment of stone lying free within a cavity such as the kidney pelvis, the bladder or a diverticulum. The use of hypersonic waves, of course, is a visionary hope for the future.

Follow-up Treatment

Follow-up treatment is a valuable adjunct in the long view treatment of urinary calculi. An intravenous urography three months or so after an episode of lithiasis provides reassurance of results and establishes a record which is of particular value in case of recurrence.

Surgical Treatment

It can be seen that the treatment of the ureteral stone resolves into a choice between the masterful inactivity of palliation and more aggressive surgical treatment. There is a wide band of borderline cases, surprises are many, and reproaches for unhappy decisions are frequent.

The small calculus in the upper ureter and most certainly the small one in the pelvic portion of the tube should be treated conservatively by palliation. Exceptions to this generalization must be made in cases with marked sepsis or when pain or bleeding are excessive. It is important to maintain high fluid intake to promote diuresis and ureteral peristalsis. A urogram is of value in confirming the diagnosis and assessing the progress of the passage of the calculi. All urine is religiously strained. A useful practice is to have

Presented at the Annual Meeting of the Manitoba Medical Association, Winnipeg, October 9th, 1952.

the patient carry and use a small tea strainer. It it surprising the doubt and uncertainty which can arise from the passage of an old blood clot. Usually it is wise to limit expectant treatment to calculi under five millimeters in diameter. If disability is prolonged and the pain is severe, surgical or endoscopic treatment should be undertaken. The one death which occurred in our recent one hundred and fifty cases was from sepsis resulting from the impaction of a minute calculi in the upper ureter. Extramural expectant therapy was followed over an eight-day period. Admission to hospital was within a few hours of an initial chill and ureterolithotomy was done a few hours later. Death occurred ten days later from Staphylococcus Aureus Septicaemia despite active antibiotic therapy. It is stated that complete ureteral blockage will cause permanent impairment of renal function after eight to ten days.

The larger stone above the pelvic brim should be removed surgically at the earliest opportunity. The operation is a brief non-shocking performance, achieving not only the immediate removal of the cause but also assurance of rapid recovery and minimal disability. It, of course, in addition eliminates the danger of kidney infection.

Stones lodged in the lower ureter are particularly suitable for treatment by endoscopic manipulative measures. From the time of Bransford Lewis, some urologists have had a certain degree of success even with calculi at a higher situ. However, the general tendency is to limit extensive instrumental dislodgement to calculi located below the iliac vessels. The Dourmaskin bag, the looped catheter of Ellik and the stone basket devised by Norman Roome are devices suitable for this purpose but efforts have to be restrained to avoid ureteral damage and the percentage of successful manipulation is not impressive. Advocated instruments and recommended procedures are too numerous even to mention and vary from simple ureteral catheter drainage over a twenty-four to a forty-eight hour period to combined instrumentation by using rigid instruments passed along the outside of an endoscope. It is axiomatic that judgment and careful consideration have to be exercised in carrying out any manipulative operation. The following points should be considered in making the decision of whether to resort to surgery or to attempt to remove the calculus by manipulation. Furthermore, it is important for the patient to understand that open surgical removal may be imperative if more conservative endeavours are failures.

1. Size. The stone must be of reasonable size.

2. Site—Below the pelvic brim.

3. General condition of the patient such as temperature may contra-indicate manipulation and demand early ureterolithotomy and ureterostomy.

4. Complicating urinary tract disease may make instrumentation unwise, difficult or even impossible. For example, the presence of prostatic hypertrophy—vesical diverticulum.

The calculus impacted in the narrow intramural ureter sometimes presents a perplexing treatment problem. Commonly the ureteral orifice is obscured by oedema and it is impossible to pass any instrument into the ureter above the calculus. Surgical removal is always possible but the site is difficult to approach surgically and usually involves an extra and intravesical exposure with subsequent troublesome and prolonged bladder drainage. Transurethral ureterolithotomy is a commonplace and useful performance when undertaken with caution and discretion. It involves resecting, transurethrally, the terminal portion of the intramural ureter to either expose the calculus or to permit access to the lower ureter.

Ratner and Schneiderman have outlined the clinical applications of the operation. We are quoting them in listing the requirements to be fulfilled before it is undertaken.

1. The calculus must be impacted in the terminal ureter.

2. Other forms of manipulation must have been unsuccessful.

3. A definite bulge indicating the site of the stone must be present.

4. The stone must be visualized by X-ray.

It is a useful and usually successful approach in the treatment of this type of ureteral lithiasis.

Complications and Sequelae of Manipulation

While the incidence of undesirable effects is extremely low and serious sequelae unusual, complications from manipulation do, of course, occur. It is common for a patient to experience a typical renal colic type of pain for a twenty-four hour period following removal of the stone. A few have an elevation of temperature. Rupture of the ureter occurred in one case. Further scrutiny of the circumstances of this case would make one conclude that a necrosis of the wall of the ureter had occurred from a large impacted calculi. Mechanical failure or breakdown are not frequent but it is imperative that the instruments be kept in first class order and that they be discarded on the first sign of too much wear and tear. Any tendency to assume a light-hearted attitude that the endoscopic manipulation of ureteral calculi is a trivial, minor office practice type of treatment can lead to disaster. In one case, pulmonary embolus followed manipulation but further examination of the details disclosed that the patient had persistent colic and a low grade fever for ten days preceding the operation.

Ureterolithotomy

Ureterolithotomy and removal of a calculus through an extra-peritoneal route is necessary in a certain proportion of cases. A calculus too large

to pass through the terminal ureter or one that fails several attempts at manipulation may require this approach. An elevated temperature or existing complications may demand this method of treatment.

Vaginal Ureterolithotomy

An unusually easy and safe approach to the lower ureter in some women is through the lateral vaginal fornix. Vaginal ureterolithotomy is a very satisfactory method of removing a palpable calculus in the lower end of a ureter in a multiparous woman.

A hundred and fifty consecutive admissions for ureteral calculus were reviewed to determine their clinical course and the method of therapy required.

Fifty-four (54) cases (34%) required no active treatment. In seventeen, the calculi were passed and recovered. In eleven (11) cases the calculi were passed and not recovered. An additional twenty-six (26) cases passed the calculi after cystoscopy and ureteral catheterization. They averaged forty-eight (48) hours hospitalization. All were negative clinically and radiologically before discharge. Manipulation was undertaken in seventy-six (76) cases (50%) of the total admitted. In fifty-four (54) cases (70%), the stone was recovered at opening and a further fifteen cases subsequently passed the stone. Thus ninety per cent (90%) of the manipulations were successful. Average hospitalization of the uncomplicated case was four days. Complications included embolism, pyelonephritis and urinary retention due to concomitant prostatism.

Open surgery was required in twenty-nine (29) cases (20%). Of these seven (7) cases had previous attempts at manipulative removal. Hospitalization in the average case was ten days and forty-four per cent (44%) were discharged within twelve days. Factors complicating and prolonging convalescence was sepsis, post-operative bleeding and concomitant kidney disease.

Summary and Conclusions

An outline of the current method of treatment for ureteral calculi has been given. It is obvious that each case presents an individual problem and requires consideration on its own merits. The endoscopic removal of calculi can be employed successfully and with a minimum of undesirable complications and sequelae in suitable cases.

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Paediatrics

Case Report

The following case report of Methemoglobinemia is reported because:

1. It is the first known case recognized in this district.

2. It may recall to other practitioners of the disease in babies of parts of Southeastern Manitoba.

The baby of six weeks was brought in by the grandmother who was looking after the child because it had been "getting blue" for the past two days. The baby was born in St. Boniface Hospital; birth weight: 8 pounds, 4 ounces. The formula it was sent home on was "too strong" and was presently on Carnation Milk: 1 part; Boiled Water: 7 parts; Corn Syrup: ½ tablespoon.

The baby appeared a definite blue color. Examination of heart and lungs was normal. The baby weighed 9 pounds, 10 ounces. Methemoglobinemia was suspected and the mother was advised to leave the child in hospital The child was put on S.M.A. (Wyeth) and in twenty hours the lips were of a definite pink color and blueness had nearly disappeared. The child gained 12 ounces in hospital in three days, and when seen two weeks later weighed 12 pounds.

Water obtained from the sand point well was estimated to have a nitrate content of between 200-300 parts per million.

The fact that the formula was nearly all "nitrate-water" made the cause apparent. Dr. H. Medovy's description (Canadian Medical Association Journal, March, 1950. Page 228) was very applicable.

M. R. Hodgson, M.D.

Anaesthesiology

Tearless Tonsillectomy

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From the Department of Anaesthesia, Winnipeg General Hospital and the Children's Hospital. Read at the Clinical Luncheon, Winnipeg General Hospital, December 20, 1951.

The sight of the screaming, terror-stricken child in the modern operating room can now be safely eliminated. With present anaesthetic techniques and agents the occurrence of this heart-rending scene demands a review of our procedures. It is a sad commentary on many of our "production line" operating rooms that all too little time is given to the subject of our ministrations.

During the past year, at the Children's Hospital and at the Winnipeg General Hospital, we have used a variation on the well-tried technique of administering Sodium Penthothal rectally. In previous studies this agent had been proven safe, and non-irritating to rectal mucosa (1, 2, 3). Almost all reports to date are on "anaesthetic" doses (i.e. 10 to 15 mg./lb. body weight).

This study was prompted by several considerations. Firstly, there was the desire to dispel fear from our candidates for anaesthesia and surgery. We do not agree with those who state that the child should have no memory of the operating room; rather he should have no fear of it. We are of the opinion that the child need not be cheated of the experience. It is usually quite an occasion and good for lots of talk about "my operation." Then, from the psychiatric viewpoint, we feel the child rather than being shielded from this everyday experience, must be helped to face up to it.

Secondly, we felt that the anaesthetic dosages were unnecessarily heavy; that too often the child appeared in "log-like" asleep before the anaesthetist. This not infrequently delayed the ether anaesthesia and surgery, but has even been a source of concern. Besides, we are too fond of children not to enjoy the dreamy, sedated child, and practise on him some of our fast-fading "art of anaesthesis."

Thirdly, aside from all humanitarian considerations, it is a blessing to the operating room personnel in their daily routine, to be spared the "crying routine." At the Children's Hospital we now have a quiet operating suite.

This is a report of our procedure.

Sodium Pentothal is classed as an ultra-short barbiturate. When administered per rectum (as a 10% solution), its action is rapid. Within five minutes, the child falls asleep. Peak effect develops in about fifteen minutes, is maintained for about one-half hour, and then tapers off rapidly. Because the metabolism of pentothal yields other hypnotic compounds, total dosage should be kept to the minimum requirement. We have set 750 mg. as the maximum dose allowable.

Subjects were the unselected cases on the regular operative slates at the Children's Hospital (in the initial study). The method was as follows:

1. The children were weighed.
2. A cleansing enema was given.
3. The children were seen by the anaesthetist, and assessed as to temperament, unfavorable features (e.g. asthma, upper respiratory infection, etc.).
4. The sedative pentothal dosage was prescribed.
5. Fifteen minutes preoperatively, the pentothal was administered rectally by the operating room nurse.
6. The nurse waited till the child became sleepy, and then removed him to the operating suite.
7. Induction was by usual methods and agents.
8. The anaesthetist judged the approximate time for the starting of the next T & A and gave the nurse fifteen minutes warning.

The results of this technique were recorded in the first fifty cases with regard to body weight, dosage, effectiveness, and postoperative rousing time. (Table I).

(a) The dosage was effective in producing quiet children in all but a few cases. If not actually sleeping, they were relaxed and free from fear.

(b) Individual response was quite variable.

(c) This dosage is minimal, and occasionally inadequate.

(d) There was no prolongation of postoperative recovery time. Indeed recovery seemed unusually rapid in some cases.

(e) One finding which was not measurable was the definitely smaller overall requirement for ether. For induction, however, just as much of the agents was required as normally, and some agent other than ether must be used initially to avoid a "bucking" child.

Discussion

We have now used this technique on over one thousand children with no ill effects whatsoever, and no case has caused alarm. It may well be that distrust for the full anaesthetic dose has arisen because of the unpredictable effect.

Some children on this sedative dosage are very soundly asleep and stir only sluggishly when stimulated (cases 28 and 38). Again, others are only slightly "toned down." We are satisfied with this latter type of failure and have learned to recognize the hyper-irritable type which requires an

Table 1

Patient	Wt. (pounds)	Dose (mg.)	Effect	Rousing Time (min.)	Comment
1. JC	34	300	Sleepy	6	Satisfactory
2. RZ	30	300	Sleeping	7	"
3. PT	36	300	Sleepy	12	"
4. BK	45	400	Sleepy	10	"
5. GB	51	500	Sleeping	35	A bit heavy for him
6. TZ	33	300	Sedated	5	Satisfactory
7. TB	44	400	Sleepy	17	"
8. RG	30	300	Sleeping	3	"
9. AW	29	300	Sleepy	5	"
10. PB	65	600	Sleepy	Awake in O.R.	"
11. MK	49	400	Sedated—whimper	7	A bit light
12. OM	44	400	Sleepy	13	Satisfactory
13. SB	39	300	Sleepy	16	"
14. TJ	45	400	Sleepy	13	"
15. RL	45	500	Slight sedation	....	Operation delayed a half hour —effect worn off.
16. RC	38	400	Slight sedation	15	Minimal effect
17. TH	35	350	Sleeping	30	Sound asleep—rousable
18. DH	34	300	Nil—crying	30	Nervous child
19. TR	47	400	Sedated	20	Satisfactory
20. TH	37	400	Sleepy	16	"
21. ME	42	400	Sleeping	14	"
22. BE	39	400	Sleeping	30	"
23. DH	25	200	Slight sedation	15	Inadequate dose
24. LP	38	400	Sleepy	10	Satisfactory
25. JB	31	400	Negligible	30	Very apprehensive, fought insertion of rectal tube.
26. MA	40	400	Sleepy	50	Long ether anesthetic
27. RA	45	450	Sleepy	35	Satisfactory
28. SD	55	500	Anesthetic	30	Lively, running about preop. Excessive effect.
29. KC	38	400	Sedated	awake in O.R.	Satisfactory
30. MM c	47	500	Sleepy	" " "	"
31. GM	60	400	Sleepy	15	Small dose adequate
32. JL	40	400	Sedated	20	Satisfactory
33. CW	31	350	Sleeping	35	"
34. PW	34	350	Sedated	45	High strung—good effect
35. PW	40	500	Sedated	40	Brother of no. 34—good effect
36. DW	30	300	Sleeping	15	Satisfactory
37. DB	42	400	Sleeping	25	"
38. SL	45	500	Sedated	30	Easily rousable but breathing quite shallow.
39. TR	36	300	Sleeping	18	Satisfactory
40. MO	26	250	Sleepy	20	"
41. JB	50	500	Slight sedation	30	" (minimal effect)
42. RS	36	400	Sleepy	14	"
43. SK	50	500	Sleeping	35	"
44. KB	34	300	Sedated	10	Nervous-could have had more
45. GP	48	500	Sleeping	26	Satisfactory
46. JT	37	400	Sleeping	12	"
47. RD	29	300	Sl. sedation	7	Minimal—larger dose better
48. MB	33	350	Sleeping	15	Satisfactory
49. DH	24	200	Sleeping	18	"
50. JK	42	400	Sedated	10	"

Definitions: 1. Sedated—Child talking quietly and relaxed
2. Sleepy—Drowsy but stirring spontaneously
3. Sleeping—Asleep but easily rousable
4. Anesthetic—Sleeping and not rousable
5. Rousing Time—Time elapsed from moment the patient arrives in his room till he responds to his name.

increased dosage up to 15 mg. per pound of body weight.

The one difficulty with this technique has been the timing of the rectal administration. Full credit must be given to the nurses who have so cheerfully taken on this extra task, particularly Miss Early at the Children's hospital. If the agent is given too soon its maximal effect has worn off before induction. There is no harm in this however, since the child remains sedated for up to one hour.

One fear we had harbored has proved groundless. Pentothal has been described as producing hypersensitivity of the larynx, resulting in spasm. When it is remembered that pentothal is a hypnotic drug acting on higher nerve centres, one will not insult the fully active (undepressed) masopharynx and larynx. Laryngospasm has not occurred in this series (i.e. disregarding the reflex glottic closure during too rapid ether induction.)

It has been our practice not to leave the child unattended once the pentothal has been administered.

Summary

1. A technique for administration of pentothal per rectum as a preoperative sedative has been described.

2. Over one thousand cases have been safely and satisfactorily prepared for anaesthesia.

3. Dosages described are minimal, effects are short-lasting (one hour or less), and therefore careful timing is important.

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Endotracheal Anaesthesia

Max Minuck, M.D., and Max Cham, M.D., Winnipeg

The merits of endotracheal anaesthesia stand established at the present time[6]. To discuss fully the advantages and disadvantages of intubation would be of no great value; but for the sake of completeness, we will briefly mention some of them, as follows:

Advantages:

1. Improvement of the airway under adverse conditions, i.e., in the prone and lateral positions, and in operations around the head and neck.

2. Blood, vomitus, pus, etc., can be cleared out of the trachea.

3. Leakage of explosive and expensive gases can be kept to a minimum.

4. In bronchiectasis and other chronic chests, the tube leads to easy suction of pus and secretions that are present.

5. It allows for smoother control of anaesthesia and relaxation in abdominal surgery.

6. Its use is almost mandatory in the open thorax.

7. Its use in thyroidectomy and tonsillectomy is usually subject to consultation between the surgeon and the anaesthetist.

Disadvantages: (These are few but important)

1. Aneurysm of the aorta-trauma may cause rupture.

2. Acute laryngitis.

3. In cases of open tuberculosis, trauma may lead to tuberculous laryngitis.

4. Lack of skill on the part of the neo-anaesthetist, if expert supervision is not available.

History of Endotracheal Anaesthesia[6]

Intubation of the trachea for the purpose of resuscitation is three centuries older than anaesthesia itself. Vesalius recorded an experiment of passing a reed into the "aspera arteria" of an animal whose thorax had been opened, and blowing into it intermittently. Over a century later, in 1667, Robert Hook performed a similar experiment before the Royal Society of London. Towards the close of the 18th century intubation of the trachea as a means of artificial respiration in cases of drowning became fairly common—and also production of pneumothorax from forcible overdistension of the alveoli, until a safety stop-catch was added to the bellows.

But of particular interest is the date 1858. It is perhaps appropriate that, what is now a recognized technique for the physiological administration of an anaesthetic over a long period of time should have originated with John Snow, the father of anaesthesia. Intubation from the neck, through a tracheotomy wound was performed by John Snow, and is still a method that sometimes has to be resorted to.

Trendelenberg used this method in 1869, occluding the trachea by means of a cuffed tube. MacEwen of Glasgow, in 1880, passed a tube from the mouth into the trachea, using a finger as a guide. Fritz Kuhn, in 1901, extended the technique by using a flexible metal tube introduced on a curved guide through the mouth.

Meltzer and Auer, two physiologists working at the Rockefeller Institute in New York, stipulated that the end of the tube must lie near the bifurcation of the trachea, that the tube must be narrow enough to allow the return of air around the tube, and that the air must be blown in at a

certain positive pressure. This referred to insufflation anaesthesia, introduced in 1907, by Barthemely and Dufour of France.

During the years 1913 to 1919 the greatest obstacle to the wide-spread adoption of endotracheal anaesthesia was progressively overcome. This was the technical difficulty of introducing the tube into the trachea. Kirstein pioneered direct laryngoscopy in 1885, and Chevalier Jackson published a book on it in 1907, but it wasn't until 1918, with the appearance of the work of Magill and Rowbotham, that the technique of anaesthesia was profoundly affected. In 1924, with the appearance of Water's carbon dioxide absorber, a great impetus was given to intubation associated with re-breathing method of anaesthesia. Inflatable cuffs had been used in the past but were now reintroduced by Waters and Geudel in 1928.

Equipment and Apparatus

The variety of endotracheal tubes is great. They range from soft rubber to a flexible metal tubing (Woodridge). They may be made of rubber, plastic, silk that is coated in such a manner so as to render it waterproof and semi-rigid, or may be made of a soft malleable metal. To dwell at length on the advantages of one versus the disadvantages of the other would be fruitless: it is rather the personal preference of each anaesthetist that determines the advantages peculiar to any particular type of endotracheal tube. The tubes may be straight or curved, or may be provided with semi-rigid directors so that the tube may be shaped to suit individual patients and anaesthetists.

As far as the optimal size of the tube to use: Beecher, by studying the concentrations of gases in the blood[2], has shown that smaller tubes than are generally supposed are entirely satisfactory. French 32-34, or Magill 7-9, are adequate for efficient exchange of gases in the lungs. Larger tubes may be used only in exceptionally large individuals. In children with naturally small glottic openings, thin-walled tubes are of particular importance. One must remember, that in an infant, the narrowest point in the trachea is at the cricoid cartilage, and it is unwise to use tubes that will pass through the glottic opening but not past the cricoid.[4]

To make the endotracheal assembly air-tight the throat may be packed off with gauze, or a cuffed tube may be used. The gauze pack is sterile and soaked with water, or it may be impregnated with vaseline, and it is packed snugly around the tube until the pharynx is filled. When the pack has been in for some time it tends to become slippery with mucus and will ride up and will thus not always ensure against stomach contents regurgitating back into the larynx alongside of the tube. A cuffed tube offers more security in this case. However, cuffed tubes have other disadvantages: the cuff may collapse without it being noticed, during light anaesthesia the pressure from the cuff may stimulate "bucking" secretions may collect on top of the cuff and then be inspired as one is preparing for extubation. Nevertheless, all these faults can be circumvented, and once again, as in other aspects of anaesthesia, personal preference dictates whether cuff or pack is better.

The tube should be lubricated with a thin film of lubricant. Oily lubricants should be avoided as danger of lipoid pneumonia does exist, and it is probably better to use water-soluble lubricants.

Repeated boilings will soften the tubes and shorten their lives. Immersion in a 1:1,000 solution of mercury biniodide or alcohol, varying in strength from 60-90%, is practicable. The metal tubes can, of course, be boiled. The lubricant used is sterile and is applied with a piece of sterile gauze. The intra-tracheal end of the tube should not be touched.

Just a few words about straight and curved bladed laryngoscopes. The straight blade enjoys a more universal use; it allows for a direct view of the vocal cords and the tube used need not be curved. The curved blade is useful particularly in people with large protruding teeth, or who are short necked. The tip is placed in front of the epiglottis and it (the epiglottis) is lifted indirectly as the base of the tongue is pushed upwards. Often the curve of the blade prevents a straight tube from being used and then one with a marked curve has to be used, or a director, bent at an acute angle, must be placed in the tube.

The Act of Intubation

The neophyte anaesthetist does not gain his spurs in the act of intubation, until he has thrown several patients into violent spasm, frightening to himself as well as the surgeon, but soon remedied by his supervisor, loosened a few teeth by the lever action of the blade of the laryngoscope, and abraded the mucus membrane of the soft palate and/or the oesophagus. Having emerged from this minor holocaust, it soon dawns on him that skilful induction of anaesthesia is more important than the act of intubation itself, which the induction can make or mar.

The chapters on endotracheal anaesthesia in the standard textbooks of anaesthesia devote many pages to the different anaesthetic agents and methods that are used and their advantages and disadvantages in relation to intubation. To summarize briefly the information contained in these textbooks we might say that, for the beginner, ether anaesthesia in the third plane is the safest agent to use. It allows for adequate relaxation of the pharyngeal muscles and sufficient time to place the tube in the trachea. For the expert we have the administration of varying proportions of pentathol-muscle relaxant drug, a waiting period

to allow the drugs to act, rapid intubation followed by controlled or assisted respiration until spontaneous adequate respirations have returned.

Whenever possible intubation should be performed under direct vision. There are times, however, when this is impossible, and "blind" intubation must be resorted to.[7] Adequate respiratory movements, aided by carbon dioxide inhalations, are essential for successful intubation. In spite of the danger of the serious reflexes that are cited below, light anaesthesia must be used. "Blind" intubation may be performed via the nasal route or via the oral route.

We may sum up the arguments for and against the use of either the oral or nasal routes (these hold true for blind as well as for direct vision intubation) as follows:

1. Choose, unless there be good reason to the contrary, the route most convenient to the surgeon.
2. Choose whichever route seems to be easier and less traumatic.
3. Avoid the nasal route in patients suffering from upper respiratory disease or presenting some form of nasal deformity.
4. Avoid the oral route in persons who have short, thick necks and a full set of teeth, and in those with fragile teeth.
5. Never yield to the temptation to overcome mechanical difficulties by the use of force instead of skill.

Reflex Effects

Uncomplicated by coughing, anoxia, or hypercapnia, direct laryngoscopy or tracheal intubation during light general anaesthesia is capable of producing decided circulatory effects characterized by a rise in blood pressure and an increase in heart rate. These changes are initiated by the laryngoscope pressing against the base of the tongue and/or lifting the epiglottis, and are independent of the type of laryngoscope used, Deeper anaesthesia obtunds or abolishes these reflexes. Cardiac reflexes do not appear during laryngoscopy but are observed when the trachea is intubated. Second or third plane anaesthesia diminishes these responses.

The importance of these reflex affects are magnified in the cardiac patient, since arteriolar pressure and cardiac acceleration place undue stress upon an already weakened myocardium. It is of particular importance in these instances to intubate the patient while in second or third plane of anaesthesia.

Vagal induced slowing of the heart has been reported, but routine premedication with belladonna derivatives diminishes these vagal responses. Increases in heart rate are the result of sympathetic reflexes; these cardio-accelerator nerves are carried along with the vagus to the heart.

Respiratory reflexes are characterized by laryngospasm and broncho-spasm. Certain muscle relaxant drugs, such as curare, have been incriminated in these severe reactions in that they may be histamine-producing drugs. However, these are generally vagal reflexes, and are obtunded by adequate premedication with atropine or scopolamine, and intubation only when the patient is in second or third plane of surgical anaesthesia.

Complications

The insertion of the laryngoscope prior to intubation may entail a certain amount of trauma depending upon the skill of the anaesthetist. Lacerations of the lips and gums, loosening or actual extraction of teeth, abrasions of the palate and pharyngeal wall, and damage to the tongue can readily occur. The tube itself may cause abrasions of the pharyngeal wall, nasal mucosa, or trauma to the supra-glottic, glottic or infra-glottic structures, or even to the trachea itself. These complications are mechanical in origin, and depend on a number of factors, such as, skill of the operator, individual anatomical characteristics of the patient, degree of relaxation, rapidity of intubation, diameter, shape, length and consistency of the tube, and duration of anaesthesia.

Proper skill on the part of the anaesthetist, paying careful attention to the depth of anaesthesia, and degree of relaxation before attempting to intubate, correct selection of the required tube for each patient will, in every case, avoid the above mentioned complications.

Other remote and rare complications of intubation are polypoid corditis, granulomatous changes in the vocal cords, or myositis of the larynx.

Mechanical complications may occur during maintenance, and the anaesthetist must constantly be on his guard to correct them. It is never a safe assumption on the part of the anaesthetist that if intubation has been performed that respiratory obstruction cannot occur. Aspiration of foreign fluids, particularly if no pack or cuff has been used can happen. Soft tubes can become kinked, especially in operations around the head when the surgeon or his assistants may accidentally lean on the apparatus attached to the tube. Biting of the tube may occur if the bite-block has become dislodged. A tube that is too long may have its tip in one of the bronchi, usually the right, and the other lung will collapse.

Several complications may occur when the endotracheal tube is removed. Trauma to the vocal cords may occur if the patient is light and grips the tube tightly with his cords as it is being removed. This is particularly prone to happen when metal tubes are being used. Respiratory obstruction may occur from severe laryngospasm or bronchospasm which sometimes follows immediately upon extubation. This is a vagal reflex and does not occur in deep anaesthesia. Treatment consists of placing the mask on the patient and

trying to push oxygen past the adducted vocal cords. Aspiration of mucus, lubricating agent, or stomach contents may occur. To prevent this the pharynx should be thoroughly aspirated and a complete tracheo-bronchial toilet performed prior and during extubation. Extubating the patient while light will enable him to cough out any offending material.

Other Uses for Intubation

1. Resuscitation—Where respiratory depression is central, as occurs with morphine and in barbiturate poisoning, intubation and artificial respiration with oxygen will have lives. Coramine, picrotoxin, etc., will avail the patient naught if an adequate airway to the alveoli is not provided. When the respiratory failure is due to obstruction as in diphtheria, pressure from oedema, abscess, etc., passage of the tube past the obstruction will, of course, be life-saving.

2. Asphyxia Neonatorum—Primary respiratory depression is easily and efficiently treated with intubation. Aspiration of stomach contents into the larynx and trachea, can be treated by passing a fine catheter under direct vision, past the vocal cords. Gentleness in suction is important if one is to avoid atelectasis.

3. Tracheo-bronchial Toilet — This may be necessary post-operatively when the patient is awake. Spray the throat with pontocaine ½% and pass the catheter blindly either orally or by the nasal route. Often the mere attempt to pass the catheter will be sufficient to induce coughing of such violent force that the offending plug may be coughed up.

4. Instillation of lipiodol — This is merely a blind intubation with a cannula through which radio-opaque material is injected into the bronchial tree.

Summary

Tracheal intubation is perhaps the greatest technical aid at the command of the anaesthetist. Easy as it may be, intubation by either the nasal or oral route can be bungled with detriment to the patient. Even when properly performed, endotracheal intubation has certain adverse features of sufficient significance to restrict its use to cases where it is really necessary.[5]

Indications for its use are clear cut and should never be exceeded merely for exhibition purposes. In any procedure, where patency of the airway is likely to be threatened by posture of the patient or disposition of the surgical team, intubation is not only advisable but essential.

The patient should be intubated while in second or third plane of surgical anaesthesia, and he should be extubated while light, in spite of the danger of certain reflex effects.

Everyone in medicine, be he anaesthetist or not, should be able to perform an endotracheal intubation with comparative ease. In the wide field of medicine there are many occasions, exclusive of anaesthesia, where adeptness at passing a tube into the trachea may be life saving.

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Tuberculosis

Immigrant Tuberculosis in Winnipeg 1950 - 1951

The following is a brief report on tuberculosis discovered during 1950 and 1951 among recent European Immigrants residing in Winnipeg:

Incidence:

During the year 1950 fourteen new cases of pulmonary tuberculosis were discovered in recent immigrants to Winnipeg and a similar number of new cases (14) in 1951. During these same years eighty-eight new cases in 1950 and ninety-six new cases in 1951 of active tuberculosis were discovered in all Winnipeg residents—excluding immigrants.

TABLE I.

Year:	All forms of new active Tb. in Winnipeg Residents (excluding Immigrants)	All forms of new active Tb. in recent Immigrants
1950	88	14
1951	96	14

Unfortunately it has not been possible to find out the total number of recent immigrants resident in Winnipeg in order to compare the sickness rate (morbidity) for Tuberculosis among our normal population to our recent immigrant population. However, the morbidity rate for tuberculosis per 100,000 population of Winnipeg residents was 37 in 1950 and 40 in 1951.

For the morbidity rates to be the same in our usual population to our immigrant population the 14 new immigrant cases in 1950 and again in 1951, would indicate an immigrant population of 37,316 for 1950 and 34,796 in 1951, or that approximately one out of every seven persons in the city is a recent immigrant from Europe. As this does not seem likely, these comparative figures indicate that the tuberculosis rate is higher among recent immigrants than among our usual population. See Table II:

TABLE II.

Year	No. new active Tb. in Winnipeg (excluding Immig.)	Winnipeg Population	Winnipeg Morbid. Rate per 100,000 population	No. new Act. Tb. in Immigrants	Required Immig. population for Winnipeg Rate
1950	88	234,561	37	14	37,316
1951	96	238,604	40	14	34,796

Mr. R. N. Munroe, District Superintendent of Immigration for the Federal Government, has informed me that since 1948, 18,124 immigrants have come to Manitoba. There is evidently no way of accurately estimating the number of these immigrants who remained in Winnipeg or who later migrated into Winnipeg from other parts of Manitoba. However, Mr. Munroe believes that not more than 8,000 or 9,000 of the 18,000 are at present residing in Winnipeg. If this estimation is correct then the incidence of tuberculosis among immigrants arriving in Winnipeg since 1948 is 4 to 5 times greater than the incidence among our usual population.

Geographic Distribution of Manitoba Cases:

The majority of new cases of tuberculosis among the Manitoba Immigrants is being discovered in Winnipeg. As is seen in Table III approximately 65% of the total number of new cases discovered in Manitoba were residing in Winnipeg.

TABLE III.

Year:	Total new cases of Tb. in Immigrants in Manitoba Excluding Winnipeg Cases		New cases of Tb. in Immigrants in Winnipeg		Total Cases of Tb. in Manitoba
	No.	%	No.	%	
1950	8	36%	14	64%	22
1951	7	33 1/3%	14	66 2/3%	21

Length of Time in Canada:

Of the fourteen new cases discovered in 1950 all of these individuals had arrived in Canada during or since 1948 and the majority had been in Canada for only one year or less. Of the fourteen new cases discovered in 1951 only one individual had arrived in Canada prior to 1948—the majority having been in Canada less than two years. See Table IV:

TABLE IV.

Year Tb. discovered	Year of arrival of Immigrant in Canada					Total Cases
	1947	1948	1949	1950	1951	
1950	0	4	9	1	0	14
1951	1	4	6	2	1	14

Extent of Disease:

Approximately 50% of all new immigrant cases discovered during 1950 and 1951 were classified at the Central Tuberculosis Clinic as moderately advanced active tuberculosis, which means their disease is beyond the early stage and has likely been existent for some considerable time. See Table V:

TABLE V.

Year:	Minimal Active	Mod. Advanced Active	Far Advanced Active	Other Forms	Total
1950	4	5	0	5	14
1951	3	7	1	3	14
Total	7	12	1	8	28

Source of Discovery:

Of the twenty-eight cases discovered in 1950 and 1951 thirteen cases or 46% were referred for tuberculosis investigation by their private physician. Six cases, or 21% were discovered during routine industrial surveys and the remaining nine cases were discovered by various other agencies. See Table VI:

TABLE VI.

Year	Industrial Surveys	X-rayed as Contact	Referred by Private Dr.	San. X-ray Clinics	Routine X-ray on Hosp. Admiss.	Total
1950	1	1	7	2	3	14
1951	5	1	6	1	1	14
Total	6	2	13	3	4	28

Treatment Costs:

According to the Winnipeg Municipal Hospital Authorities it costs $6.89 per day to treat each case of tuberculosis in the King Edward Memorial Hospital. Depending on the category under which the immigrant entered Canada, this daily treatment cost is borne in various proportions and combinations by the Federal Government, Provincial Government, the City or by industry.

It is estimated by various tuberculosis specialists that the average length of stay in Sanatorium for even minimal tuberculosis is eleven months. Moderately advanced cases of the disease require considerably longer periods of sanatorium care. As approximately 50% of the new cases were in moderately advanced stages it would seem logical to assume that the average length of stay in Sanatorium would be at least one year. On this basis, to treat the cases found during 1950 and 1951 in the King Edward Hospital would have cost approximately $70,000. In addition to the cost of sanatorium care, the City, in some cases, has become financially responsible for the support of the dependents of the new case of tuberculosis during his or her period of hospitalization.

The existence of an unusual amount of tuberculosis among recent European Immigrants compared to our usual population, creates a financial responsibility for the Municipal, Provincial or Federal Governments and in addition has an adverse effect on local tuberculosis prevention activities.

Although the incidence of tuberculosis has been shown only for 1950 and 1951, a similar problem existed prior to these years and still exists. Indeed, some immigrants discovered to have tuberculosis prior to 1950 are still on sanatorium treatment and new cases are being discovered every month. The latest immigrant case of tuberculosis to be reported to the City Health Department was discovered in an immigrant who had been in Canada only six weeks and her disease was classified as far advanced active pulmonary tuberculosis.

It is recommended that the high incidence of tuberculosis being discovered among recent European Immigrants in Winnipeg be brought to the attention of the Canadian Immigration Authorities in Ottawa and that more rigid measures of medical examination by the Department of Citizenship and Immigration be urged. It is also suggested that the extent of this problem be brought to the attention of the Canadian Tuberculosis Association in Ottawa.

R. G. Cadham, M.D., D.P.H.,
Deputy Medical Health Officer.

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Manitoba Medical Association

Presidential Address

Delivered at the Annual Meeting of the Manitoba Medical Association, October 9th, 1952, by Dr. A. M. Goodwin, Retiring President

Prepaid Medical Care Plans

Canadians today are a favored people, in the throes of a period of unprecedented prosperity. The average wage earner is living at a level of comfort and security not dreamed of by our forefathers. The thought of "Security" is uppermost in the minds of all, and is being sponsored by government to a degree that if carried too far may work to our detriment.

It is to be hoped that the advice of great men of past days may not altogether be lost sight of. It was Abraham Lincoln who said: "You cannot build character and courage by taking away men's initiative and independence." And likewise said he: "You cannot help men permanently by doing for them what they could and should do for themselves." And remember too that "If a man does only that which is required of him, he is a slave. The moment he does more, he is a free man." (Farm Journal).

Freedom is not the right to do as you please but the privilege of doing what is right.

I would like at this point to quote from the Bulletin of the Vancouver Medical Association the following summary of the programme of International Labor. "As an organization of the United Nations they are working for a compulsory welfare state. They propose to try and induce member nations to ratify the "Social Security Package Plan" which they have worked out. The plan will be compulsory, and under Government control and ultimately all medical benefits, hospital care, and appliances are to be free to everyone.

What answer has organized medicine to such a proposal? Some way must be found to make the very best medical care available to every citizen, at a cost commensurate with his ability to pay. Our answer lies in "Prepaid Medical care plans."

If we fail in this endeavour we shall have a compulsory welfare state plan, and we must do all in our power to prevent that which we believe to be bad, not only for ourselves but for those who require our services and for the community in general.

I repeat here the statement issued by the World Medical Association, as follows:

(1) When social security schemes are necessary, they should develop in closest collaboration with the medical profession.

(2) The fundamental aim of a social security scheme should be to raise the individual to a level at which he can help himself. From this it follows that:

(3) Any social security scheme should contain elements that encourage self-reliance, and a sense of personal responsibility, and

(4) Any social security scheme should stress the obligation of the individual to make at least part of his contribution directly to the functioning, and costs of the scheme."

You will have noted the recent announcement that the Provincial Committee reporting to the Federal Government on Manitoba Health Services, approved a health insurance scheme for all Canada, but the plan should as far as possible be voluntary. It further recommends that any health insurance scheme should be provincially administered—contributory where possible, and should use "as extensively as possible" the existing non-profit voluntary agencies already providing hospital and medical care.

I suggest we take seriously the recent remark made by the Minister of Health for Canada that, "work is the only source of social security we have yet discovered."

Good medicine today insists that the patient and his circumstances be studied in every phase of interaction. From this we conclude that the economic welfare of our patient is our concern, as much as his bodily ills. Let us remember too, that doctors of Medicine have assumed the responsibilities once so ably discharged by the monks of old in their care of the sick as a quasi-religious duty. Do not patients still become a little uncomfortable when money is even remotely mentioned in connection with medical care? In various ways, the quasi-religious tradition has been observed through the ages, and there does not appear any valid reason to justify the profession's handing over its duties to others, without assurance that the rights of the sick will be fully safeguarded in the new as in the old regime. We are still custodians of the welfare of our patients. This accepted, we are now met by the universal demand throughout the world for practical means to solve the problem of providing adequate and appropriate medical care within the capacity to pay of the lowest paid artisan.

To find how the problem has been handled, let us take a birds-eye view of the world situation, then a closer look at our own efforts in Canada and particularly in Manitoba.

Despite the clamour of the Soviet to be first in everything, the astute Bismarck of Germany was the pioneer of compulsory planning. On January 1st, 1884, he launched his scheme and it is clear from Eyck, his Biographer, that Bismarck was

motivated solely by sheer political aims. The experiment was duplicated by others, and we find in 1911, that Lloyd George of Great Britain, introduced his compulsory plan for employed persons. Norway and Iceland followed. In 1917, Russia, under Lenin gave the first "cradle-to-the-grave" plan of nationalization of medicine. Hitler too, became interested. France, in 1918, toyed with a plan, as did Belgium in 1945.

The diverse plans in Europe can be grouped under the German or Russian pattern. In the former, beneficiaries were insured, and pay roll taxes were levied on employers and employees; cash benefits were proportionate to contributions. In the Russian pattern there was no insurance basis. The security scheme was carried by the general tax payer and benefits were not related to contribution, but to need or the patients' desires. Today the French and British schemes have many features of the Lenin pattern, while the German programme follows that of Bismarck.

Regardless of type, there are features of the compulsory plans which may deserve notice here. Firstly, the evidence is abundant that the taxes in Germany, France and Britain increased even with virtually stable price levels. Secondly, administration costs were high and accounted for four-fifths to five-sixths of the social security administration costs. Also, incidents of illness or absenteeism showed a definite increase. More important than all this has been the deterioration of medical services. The doctor has found no economic freedom outside the monopoly established by the state.

The points in favour of Compulsory Governmental Insurance as outlined in a Bulletin circulated by the Committee on Medical Economics of the Canadian Medical Association are as follows:

(1) People not ordinarily interested are required to come under the protection of the Government plan, so that groups covered are often much larger.

(2) So far as the insured person is concerned, the financial sufficiency of the plan is assured, for the Government, in case of insolvency, usually must provide the necessary funds; and

(3) Certain contributions are obtained from many of the lower wage earners, which otherwise it is said might be spent "unwisely," and would not be used to purchase insurance coverage.

The disadvantages of compulsory Governmental insurance are that

(1) The governmental regimentation which is inherent in any compulsory plan may be felt, in many cases, to be an unwarranted interference with personal liberty.

(2) The plans are based on the idea of making the employers, and the general taxpayers responsible for about two-thirds of the costs of the scheme, so that the employee shifts a part of his own economic problems on to the shoulders of other persons, namely, the employers and the public at large.

(3) The plans consequently have a tendency to develop artificial economic pressure and malingerings of many kinds, with the object of obtaining personal advantages over those other persons who are compelled to contribute to the costs but derive no benefits; and

(4) The plans generally cover only certain specified employees and then only while they earn not more than some arbitrarily pre-determined figure; all others are excluded, whether they earn much or only a very little more, or nothing at all.

Other disadvantages may be mentioned namely:

(1) There is no evidence that such plans have been successful in providing medical care, or in reducing the financial burden of illness.

(2) A welfare state under the guise of benevolence and humanitarian equality is a stepping stone to the police state as seen in certain European nations.

To quote from Lenin, "socialized medicine is the keystone in the arch of the socialist state."

Now what are some of the points in favour of the "voluntary plans."

(1) The preservation of individual personal liberties—freedom of choice of doctor, hospital, and type of service.

(2) The real interest which members of any voluntary co-operative effort naturally feel in protecting and enlarging the usefulness of their own endeavours.

(3) Voluntary plans can be made to cover any economic group so long as the necessary contributions for insurance are paid, and the conditions for insurance are fulfilled, and

(4) Voluntary insurance is simply a method of sharing burdens — there is no attempt to make other people responsible for the individual's own problems.

Now with all these facts before us what is the ideal we should aim for. Obviously it is some form of Voluntary prepaid plan that will fulfill the following requirements:

(1) It should provide varying types of coverage geared to fit different budgets.

(2) For those in proven need, and unable to find a premium, a subsidy no doubt could be found. (This agrees with the statement of policy of the C.M.A.)

(3) Control of the plan should be on a regional basis, or by a non-political commission.

(4) Professional sponsorship is essential.

(5) The maximum should be returned to the subscriber in the form of benefits.

(6) Underwriting of the plan might be undertaken by those rendering the service—as in the case with M.M.S. (You will remember that the scheme was underwritten to the amount of $5,000.-00 by the College of Physicians and Surgeons; to

the amount of $1,000.00 by the Manitoba Medical Association; to the amount of $500.00 by the Winnipeg Medical Society. Also notes from practically all practising physicians of Greater Winnipeg for $100.00 each were obtained).

Let us look around at programmes of voluntary health insurance. There is little left in Europe for us to study. In Australia, however, the plan of Sir Earle Page promises great things. In essence this plan envisages a partnership of Government, subscribers, and the voluntary prepaid plan.

Coming nearer home, we find in the U.S.A. a furor of activity. There the problem has bitten into the people, and there is great excitement, and even fear that socialized medicine is on its way. Now it is characteristic of medical care plans in the United States that coverage is very limited; indeed in most of them it is more restricted than that provided by our own Plan A. The American plans are at best surgically minded. Apparently there is no one willing to underwrite the deficit, and in this willingness to do so, lies the incomparable contribution of the Medical Profession of Manitoba operating under M.M.S., such absorption of deficits is the guarantee of a plan's stability during any economic depression.

Getting nearer home we find in Canada a blessed atmosphere favorable to a pioneering good-neighborly spirit. The problem of medical care has been realistically and sympathetically handled from Nova Scotia on the East to British Columbia on the West. We have medical care plans in every province, all co-operating, yet autonomous in each province, with jealous regard for the special needs, and custom of practice in each province. Now we have Trans-Canada Medical Services as an integration of these plans across Canada. Much of the credit for the ground-work of Trans-Canada Medical Services should go to the two imaginative heads—Dr. Routley and Dr. Kelly. To its first chairman, Dr. McNulty, the profession owes much. By his enthusiasm, and blunt courage, he provided the machine and gave it initial momentum for its first year.

Now to come home to our own province. Manitoba doctors have brought to the task a sense of social justice, and benevolence that cannot be equalled on this continent. Where in this world will you find a medical plan that offers so much to the patient? Consider the unlimited range of radiology without regard to cost, the availability of care in the office, home or hospital; the well-baby care, the multitude of diagnostic services; the absorption of deficits by you — the medical members, and above all the absence of extra billing by Specialists or General Practitioners. As I see it, there is no plan in this country, save M.M.S. offering so many advantages to patient and doctor.

I cannot appeal to you too strongly to get behind this movement. Your loyalty and team spirit are essential to its welfare. And remember you are all partners in it. This is not any more a scheme for the City of Winnipeg alone, but for the entire province.

Your M.M.S., whether you realize it or not, is being watched with great interest by students in this field all over the continent. I believe I am right in saying that you have the first building owned and operated by such a Medical Care Plan in Canada, and probably in the world. (There are some, however, operated in conjunction with Blue Cross Plans). Also, you now probably have the first plan with a microfilm service and you last week received your Manual, which is the first of its kind to be published.

As stated before, if this plan fails we shall have a compulsory welfare state plan thrust upon us.

To the Manitoba Medical Association belongs the honour of breathing life into this amorphous thing in 1942. We have sponsored it, endorsed it and supported it. Though a corporate body and always autonomous, the M.M.S. Board has always co-operated in every respect, and takes guidance in matters of policy from you—the members of this association.

An enterprise of this kind can hardly be successful without the ardent support of the public, and that has been given abundantly, not only by the subscriber, but by a great number of public spirited men who have given of their time and talent with no thought of remuneration, in acting with medical men as trustees on the Board of Governors. It is my opinion that these shapers of policy should not be too readily replaced. Here is an experiment in medical economics which has been uniquely successful. Let us look after it, and keep alive in it the principles animating it in its infancy.

Through M.M.S. you have relieved the burden of sickness and revived hope and brought happiness to many persons. As we go on, the road may become rougher—but this shall not be if we act with one mind. It is a time for re-affirmation of principles. We shall need unity in the profession, and we look to you again for loyalty, fellowship ,and above all tolerance in our endeavour. We are all equal partners in a unique enterprise, devised, and working for the benefit of all.

Manitoba Medical Association

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Senior Membership, C.M.A., 1953—Nominations of Manitoba Division — Doctor Hugh McGavin, Plum Coulee; Doctor Alexander Gibson, Winnipeg.

Winnipeg Medical Society

The regular meeting of the Winnipeg Medical Society was held at the Medical College on the 21st of November. The programme for the evening consisted of a panel discussion on the diagnosis and treatment of the anaemias, under the Chairmanship of Dr. J. M. Lederman. The other members of the panel were Dr. J. M. Kilgour, Dr. P. T. Green, Dr. Sydney Israels and Dr. G. E. Large.

The discussion consisted of a series of questions and answers designed to cover rather completely a very large subject and, in this respect, was very successful. The discussion apparently generated a good deal of interest in the audience since the number of questions submitted from the floor could not all be answered for lack of time.

At the end of the programme, Dr. P. H. McNulty gave a brief talk on the method of financing the new Manitoba Medical Service Building and a resumé of Dr. McNulty's talk will be published in a later issue of the Review.

* * *

For the benefit of busy medical practitioners, the Winnipeg Medical Society has arranged for the Medical College reading rooms to be open evenings from 8 to 10 p.m. until the 30th of April, 1953. It is to be hoped that this facility will be utilized to the fullest.

* * *

At the meeting of the Executive of the Winnipeg Medical Society on November 17, several appointments were approved. Amongst these were the appointment of Drs. Gerard Allison and L. A. Sigurdson as Publicity Committee for the Society, Dr. R. A. Tanner as Chairman of the Civil Defence Committee, and Dr. Harry Medovy as Representative to the Child Health Service.

Winnipeg Medical Society

The Winnipeg Medical Society held its regular December meeting on Friday the 12th, at the Medical College.

The programme consisted of a round table discussion of the management of diseases of the gall bladder and biliary tract.

The members of the panel were Dr. D. L. Kippen, acting as Moderator, and Doctors C. W. Clark, R. O. Burrell and D. W. Penner.

This was a very interesting discussion, and although the subject was considered in some detail, the program was over in very good time. Perhaps the most important feature of the discussion was the emphasis placed on the difficulty in being certain whether symptoms of dyspepsia were, in fact, related to disease of the gall bladder or biliary tract in any particular case; the difficulty arising partly because gall stones are known to exist sometimes for many years without producing any symptoms and also because similar symptoms may occur in people in whom there is no discernible disease. It is pretty generally agreed that poor surgical results often were to be traced to the difficulty in being certain whether the gall bladder was responsible for the particular symptoms. A good deal of interest and enthusiasm was also aroused by the very evident interest of the surgical members of the panel in the difficulties of managing their cases post-operatively with particular reference to the problem of stones remaining in the common duct.

The meeting ended in a somewhat hilarious note as there occurred some little confusion between amylase and phosphatase and the members departed for their coffee in rare good humour.

Refresher Course

The dates for the 1953 Refresher Course have been fixed for April 13-17th inclusive. The full programme which is now being prepared will be published in later issues of the Review.

One of the guest speakers is Dr. Hugh Jackson Morgan, B.S., M.D., D.Sc., Professor of Medicine at the Vanderbilt University School of Medicine and Physician-in-Chief of the Vanderbilt University Hospital. He holds appointments in various medical associations, among which are the American Heart Association, American College of Physicians, Consultant to the Surgeon-General U.S. Army, Johns Hopkins Medical and Surgical Association, of which he was President in 1950; Rockefeller Foundation International Health Division, of which he was Scientific Director from 1946 to 1948; and on the Central Advisory Committee on Radioisotope Research of the Veterans Administration.

Dr. Morgan enlisted as a private in the American Army in 1917 in the First World War. In the Second World War was Lieutenant-Colonel of the U.S. Army in 1940 and on his discharge in 1946 was Brigadier General with the position of Chief of Medical Consultants Division, Office of the Surgeon-General. In 1945 he was awarded the Distinguished Service Medal.

Dr. Morgan has written extensively on medical subjects, having contributed to several books and over seventy papers in various medical journals.

General Practitioners

General Practitioners' Association of Manitoba
In Affiliation with the Manitoba Medical Association

About 35 doctors are taking the Refresher Course in Pediatrics, sponsored by the General Practitioners' Association of Manitoba in conjunction with the Department of Pediatrics of the University of Manitoba.

This course which began in November will continue throughout the winter; one lecture a week. Those that would like to attend the balance of the lectures can do so by making arrangements with the President of the Association.

L. A. Sigurdson, M.D.

Executive Officers 1952-1953

Past President ..... Jack McKenty
President ..... Vladimir Ferdinand Bachynski
1st Vice-President ..... William James Boyd
2nd Vice-President ..... Glenn Forrester Hamilton
Secretary ..... James Ferguson Edward
Corresponding Secretary ..... —Margaret Owens
Treasurer ..... Solomon Malkin
Executive Members: Bronislaw Dyma, Henry Guenter, William George Newman, Aaron Jack Winestock.

Chairmen of Standing Committees

Committee on Public Relations and Publicity: L. A. Sigurdson.
Programme Committee: D. Hastings.
Educational Committee: M. Brown.
Scientific Committee: J. McKenty.
Hospital Committee: L. J. Mongeon.
Committee on Economics: A. T. Gowron.
Membership and Attendance: R. O. Flett.
Social Committee: A. J. Winestock.
Committee on Constitution and By-Laws: W. J. Boyd.
Nominating Committee: 3 past presidents.
Committee on Resolutions: N. Corne.

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Professor Frank B. Walsh of Hopkins

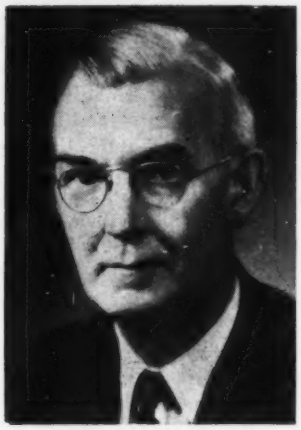
Local Medical Graduate Returns as World Famous Eye Specialist, to Address Manitoba Medical Association

It is a matter of great pride to the University of Manitoba and the citizens of this province to have Professor F. B. Walsh address the Annual Meeting of the Manitoba Medical Association after he has attained world wide eminence through his studies and publications over the past twenty years at the Wilmer Institute, Johns Hopkins Hospital in Baltimore.

Although studies and research in diseases of the eye have been carried on extensively for a great many years Dr. Walsh's investigations have the unique merit of co-relating the conditions in the eye with disease in the brain and other parts of the body. As the eye is really a part of the brain and it may be examined minutely, the eye conditions described by Dr. Walsh have been of great assistance to practitioners in every field, and it is for this reason that Dr. Walsh is held in such high regard in general medical circles.

Following distinguished army service as an infantry lieutenant in the First World War he graduated in Medicine from the University of Manitoba in 1921. After a surgical internship at the Winnipeg General Hospital he engaged in practice at Estevan, Sask., for eight years. This was interrupted by periods of study at Edinburgh where he received the degree of F.R.C.S.

In 1930 he entered a four-year period if training in Ophthalmology at the Wilmer Institute, Johns Hopkins Hospital. His good record as resident led to his appointment as Assistant Director of this famous institute, and it provided the opportunity for his many and varied investigations



PROFESSOR FRANK B. WALSH

recorded in medical journals, often as leading articles. He is the author of a large and important volume on "Clinical Neuro-Ophthalmology," published in 1947. The following year he was invited to address the Sixth Australasian Medical Congress held at the University of Western Australia, and he is in great demand as a speaker at medical meetings throughout this continent.

Dr. Walsh gave two papers at the Manitoba Medical Meeting. On Thursday afternoon his subject was "Bilateral Blindness with Acute Onset: Differential Diagnosis." On Friday he spoke on "Some Ocular Signs of Head Injuries."

Book Reviews

Medical Milestones. About few things is the layman more curious than about disease. And there is much catering to this curiosity by lay writers. But just because these authors are laymen they tend to distort facts in order to satisfy their enthusiasms or their flair for the dramatic.

For that reason an authoritative, balanced, story from the pen of a medical writer should be welcome to medical and non-medical readers alike. "Medical Milestones" is such a book. It is interesting, easy to read and accurate in its facts. It is not written for doctors but doctors will enjoy it just as much as will their patients, because sometimes the reduction of technical subjects to non-technical language makes them clearer to the professional reader.

The book deals with advances in treatment and its scope can be gathered from the chapter headings:

The Mold Era—Early Antibiotics; First and Still Foremost—Penicillin; Threat to Tuberculosis —Streptomycin; A Truce With Typhus and Typhoid—Chloromycetin; The Widest Range—Aureomycin; Bacteria Against Bacteria—Bacitracin and Polymxin; Medical Shrapnel—New Treatments for Anaemia; Blue Babies to Pink—And Other Developments of Heart Surgery; Spoiled Sweet Clover—Less of That Clotting; Goiters Slowed Down — The Anti-Thyroid Drugs; Hormones and Cancer—Chemical Warfare on Malignancy; Animal Factors in the Blood—The R.H. Story; From Poison Gas to Medicine—British Anti-Lewisite; If Anyone Touches a Leper—Drugs and Attitudes; Hope for the Rheumatic—Cortisone and ACTH; "Million-Murdering Death" — Concerning Malaria; Once Biting Twice Shy—Insects and D.D.T.; Mal-de-Mer—Dramamine.

The author is a Bermudan, and was Rhodes Scholar from Bermuda in 1936. He spent his first two years at Oxford in Classical studies and then went on to his B.M., B.Ch., which he took in 1944. At present he is Assistant Professor of Medicine in the University of Maryland.

"Medical Milestones" is the sort of book that one can recommend for the intelligent layman but doctors also will find it not only enjoyable but instructive as well.

"Medical Milestones," by Henry J. L. Marriott. Foreword by Sir Alexander Fleming; Williams and Wilkings Co., Baltimore, 1952. Published in Canada by the Macmillan Company of Canada Ltd., Toronto. Price $3.50.

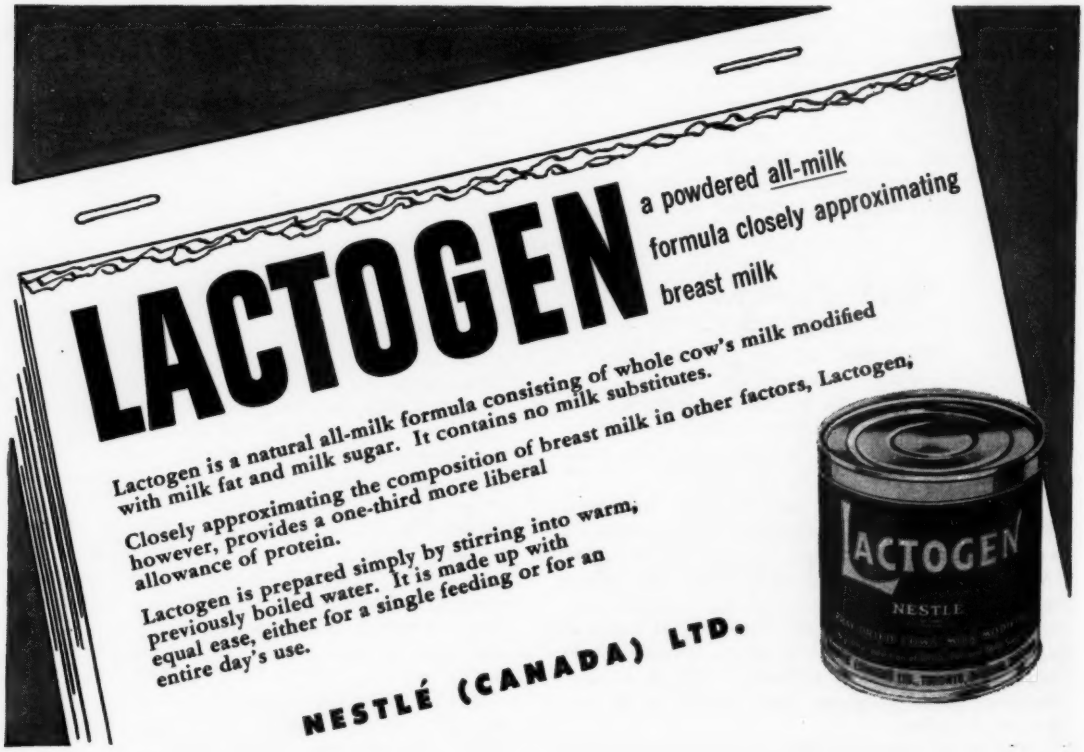
Aids to Surgery. For almost half a century "Aids to Surgery" has been amongst the most popular of books with medical students. The fact that it has endured so long and gone through so many editions is proof not only of its popularity but of its value.

The present (8th) edition is written by Reginald C. B. Ledlie and Michael Harmer. It is a pocket-size volume of 352 pages and the contents are divided into twenty-eight chapters which include all the usual and important surgical conditions with the exception of fractures and orthopedics. On these subjects there are special volumes in the "Student's Aid" Series.

The authors state that by rearrangement it has been found possible to include the important surgical advances made during the past ten years.

A book of this sort is especially valuable to the student who wishes to master the essentials of the subject or who wishes to review it quickly. For practitioners also it is useful because it makes it possible for them to refresh their memories of topics which they may not have had much contact. These small books leave out nothing that is important and include little that is extraneous and, for these reasons, are quite proper reading for all who practice surgery.

"Aids to Surgery," by Reginald C. B. Ledlie, M.B., B.S. (London); F.R.C.S. (Eng); Surgeon, the Royal Cancer Hospital; Senior Surgeon, the Miller General Hospital; Senior Surgeon, East Ham Memorial Hospital; Consulting Surgeon, the Manor House Hospital, and Michael Harmer, M.B., D. Chem. (Cantab.); F.R.C.S. (Eng.); Assistant Surgeon, the Royal Cancer Hospital; Assistant Surgeon, Paddington Green Children's Hospital; Surgeon, St. Mary's Hospital. 8th Edition, 352 pages, illustrated. The Macmillan Company of Canada Ltd., Toronto. Price $1.45.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Social News

Reported by K. Borthwick-Leslie, M.D.

Welcome to Canada to Dr. and Mrs. John Honig, London, England, who stopped over in Winnipeg, en route to Swan River, Man. Dr. Honig will be in practice with Dr. D. M. I. Hormer, they are old friends, from overseas days. Good luck and best wishes to the Honigs, hope our Manitoba winter isn't too much of a shock.

♦

Dr. Jessie McGeachy, Saskatoon, was in town last week, looking wonderful. She reports that Wendell is very happy and interested in his University work, that the youngsters love Saskatoon, and she herself has enjoyed her leave of absence from medical work, but is opening her office next month. While here she visited with Dr. Christine Curran, in her new apartment. They were at home Sunday afternoon to we medical women, much enjoyed by all. Our loss is Saskatoon's gain, Jessie.

♦

Preliminary congratulations to all those who received new degrees, certification, etc. I believe the official lists are not received as yet. More anon.

♦

Christmas Greetings from the Manitoba Medical Association to our older members brought interesting responses from Dr. and Mrs. A. B. Chapman, Reston, Man. Dr. Chapman is 89 years young.

Dr. and Mrs. Metcalfe, Portage la Prairie, and Dr. and Mrs. Stevenson, Belmont, Man.

Mrs. Stevenson also reported that their son Dr. (Capt.) Stevenson, recently returned from Korea, and decorated for his work there is now in Dublin, at the Rotunda, doing post-graduate work before returning to Minnedosa to practice.

♦

Speaking of our highly respected older members it was with regret that I heard of the death of Dr. W. G. Campbell, 77 years, who for many years worked for and with us all. Sympathy to his family and many friends.

♦

Dr. B. H. G. Curry, graduate of Manitoba Medical College, has been appointed chief medical officer for the Workmen's Compensation Board of Ontario. His picture looks "grim" enough for the job, but surely that is newspaper photography. He used to be most affable and human looking and will need to be in Compensation Board work!

♦

"Fish" stories in January? Have just heard that Cliff Abbott has a formidable competitor. One long week-end Dr. A. M. Goodwin and party went fishing in Lake Manitou out of Dryden, Ont. Alex, with superb finesse, landed a 24 pound Lake Trout. Much to his surprise a short time ago he received a beautiful new fishing rod, first prize, from the Fort Frances District Fishing Club. Only one further catch—a suitable reel cost Alex plenty. Anyway he also snatched the New Year's babv so perhaps will receive enough 1953 dividend on that to cover "reel" expenses.

Dr. and Mrs. John Gerald Fox, married recently, have taken up residence in Los Angeles. The bridegroom is the son of Dr. and Mrs. R. G. Fox, Winnipeg.

♦

Anyone want a tip as to where to have a quiet, restful New Years? The Pas of course. Tired and fed up, I decided to accept the invitation of very good friends. Slept through, what must have been a smooth air trip, and shortly found myself installed in a beautiful room with bath in the Cambrian Hotel. Have never met so many perfectly naturally hospitable friendly people. Wonderful. If firm and persistent, one can catch up with sleep during the day. The widely scattered town is ably cared for by the nicely equipped hospital and two groups of doctors all happy and prosperous. We spent a very enjoyable few hours at Dr. Clint Crawford's home. Clint and I had fun catching up on gossip re mutual old friends, army and civilian. By the way, Dr. Leister, what about that final request of mine? Am waiting for a report! Have decided that the Trappers Festival in February would probably finish me, so will probably be back for Easter, that should be quieter.

♦

Major Alan Davidson returned from Korea shortly before Christmas, dropping in to say "Hello" one night. He looks wonderfully healthy, and enjoyed his stay in Korea and Japan. He is now at Deer Lodge, so will probably be giving us more detailed accounts of conditions, etc., which will be most interesting and informative.

♦

Attention 944 Windermere—I apologize for the "moron" capacity of my taxi drivers, who apparently mistake your house for 944 Sommerville, but considering that I use the same taxi firm all the time for my night calls—unless I know exactly where my destination is, and having a very ill brother in the General with an influx of family, all using the same firm I really think either the taxi firm or Fort Garry street signs should be blasted—not me. I have made my apology, perhaps one is also due my brother's wife. Incidentally that particular car had been called two hours before, also most of the policemen are either friends or patients of mine.

♦

Dr. and Mrs. Duncan Govan are pleased to announce the birth of their second son, Dec. 17, in Chicago, Ill.

♦

Dr. and Mrs. Hugh MacDonald, Kingston, Ont., (nee Muriel Bjornson) are happy to announce the arrival of Sigrid Annette, Dec. 19, in Kingston.

♦

Dr. and Mrs. Guthrie Grant announce the birth of "Ian Guthrie Bedson Grant," Dec. 31, in Oshawa, Ont.

♦

Dr. and Mrs. Peter Berbrayer announce the birth of their son, Dec. 13, Maternity Pavilion.

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Association Page

Reported by M. T. Macfarland, M.D.

Have You an Extra Bedroom?

The Canadian Medical Association Annual Meeting will be held in Winnipeg, June 15th to 19th, 1953.

The Manitoba Medical Association will be the HOST Division.

There are NOT nearly enough hotel beds to accommodate all those whom we hope will attend the meeting.

Accommodation at the headquarters hotel will be reserved for distinguished guests, speakers, Council members and exhibitors.

Other hotel accommodations will be listed in the January, 1953, issue of the Canadian Medical Association Journal.

Members of the Manitoba Division are requested, if possible, to arrange to stay with relatives or friends.

Winnipeg members are requested, if practicable, to accept one or more visitors as guests.

Please notify the Chairman of Housing Committee, Dr. E. Dwyer, c/o 604 Medical Arts Building, Phone 93-1469.

Fee Schedule — Workmen's Compensation Board

As reported at the Annual Meeting in October, a happy solution was reached in connection with Surgical Fees payable to the profession. A new schedule (green colour) indicated that the agreement between the Board and the Negotiating Committee was to be effective for a three-year period from October 1st, 1952. For a limited period accounts submitted under the former schedule were adjusted, but members are advised to submit accounts in accordance with the new schedule.

Additional copies are available on application to the Workmen's Compensation Board, Portage Avenue East, Winnipeg, Manitoba.

Clinical Luncheons

Clinical Luncheons are held at 12.30 p.m. at the various Winnipeg hospitals shown:

Deer Lodge	First Monday
General	First Thursday
Children's	First Friday
Misericordia	Second Tuesday
St. Boniface	Second Thursday
Victoria	Second Friday
Grace	Third Tuesday
General	Third Thursday
St. Joseph's	Fourth Tuesday
St. Boniface	Fourth Thursday
Municipal	Fourth Friday

An attempt is being made to list Outpatient Clinics, Clin-path Conf., Ward Rounds, etc.

The Winnipeg Medical Society usually meets at 8.30 p.m. on the third Friday of each month.

Brandon and District Medical Association

A meeting of the Brandon and District Medical Association was held at the Manitoba Sanatorium, Ninette, on the afternoon of Wednesday, November 12th, 1952.

Present were: Doctors J. E. Hudson, President, Hamiota, and R. F. M. Myers, Secretary-Treasurer, Brandon; G. L. Hermitte, Baldur; J. B. Baker, J. B. Chetwynd, M. Dougan, J. M. Matheson, H. MacIntyre, W. S. Peters, A. H. Povah, F. J. E. Purdie, U. Quint, E. J. Skafel of Brandon; W. J. Sharman, Clanwilliam; R. E. Helgason, Glenboro; W. K. Hames, Kenton; F. J. Lone, Killarney; P. Mari, A. L. Paine, O. Sobel, W. Zajcew of Ninette; A. J. Elliott, Oak River; T. Daffron, Major Drew of Shilo; C. W. Wiebe, Winkler; J. D. Adamson, A. R. Birt, A. M. Goodwin, M. T. Macfarland, E. L. Ross of Winnipeg.

At the business session presided over by Dr. J. E. Hudson, Dr. J. B. Baker, Brandon, was elected President for the ensuing year; Dr. W. J. Sharman, Clanwilliam, Vice-President; Dr. R. F. M. Myers was re-elected Secretary-Treasurer, and Dr. J. A. Findlay, Brandon, was named representative to the Manitoba Medical Association Executive for the year 1952-1953.

The President called on Dr. A. M. Goodwin, Retiring President of the Manitoba Medical Association, to say a few words and introduce Dr. C. W. Wiebe, President of the Association for 1952-1953. Dr. Wiebe expressed appreciation for the confidence placed in him and stated that he would do everything in his power to advance the interests of the Association. Dr. J. D. Adamson made an announcement concerning the work of the Canadian Arthritis and Rheumatism Society, and a resolution requesting the Society to establish a Mobile Physiotherapy Unit in Brandon was approved by the meeting. Dr. M. T. Macfarland outlined some of the highlights of the recent Annual Meeting, including the successful conclusion of negotiations with the Workmen's Compensation Board, and mentioned the two major items for the ensuing year would be negotiations with the Cancer Relief and Research Institute and the Annual Meeting of the Canadian Medical Association in June.

Dr. A. R. Birt, Winnipeg, discussed "Common Skin Conditions" and presented three short clinical

cases. The work of the Sanatorium in dealing with Tuberculosis was ably presented by the Superintendent, Dr. A. L. Paine, while Dr. W. Zajcew read a short paper on the "Use of Isonicotinic Acid Nydrazide."

Following the business session, members joined their ladies, who had been entertained at the home of Dr. and Mrs. A. L. Paine, and a social hour was enjoyed before all sat down to a delicious meal served through the courtesy of Miss Farquharson and prepared by the dietitian and her staff. A presentation was made to the Retiring President and Dr. J. B. Baker introduced the guest speaker, Dr. J. D. Adamson, whose discussion on "Laughter," the result of considerable scientific research, produced a pleasing result in the audience. A word of thanks was extended by Dr. J. M. Matheson.

Northern District Medical Association

A meeting of the Northern District Medical Society was held at Dauphin on Wednesday, Nov. 26th, 1952.

Present were: Doctors W. G. Ritchie, President; M. Potoski, Secretary-Treasurer; R. E. Dicks, A. S. Little, B. Symchych, J. Woods, Dauphin; B. Jonsson, Benito; M. Hokanson, Ethelbert; T. Kinash, Gilbert Plains; E. Barr, McCreary; E. Otke, Roblin; T. F. Malcolm, Swan River; C. W. Wiebe, Winkler; K. Davidson, M. T. Macfarland and D. A. Sherman of Winnipeg.

Following a delicious dinner served at the General Hospital by courtesy of the Matron, Miss M. Pearson, the Dietitian and her staff, the meeting was convened at 8 p.m. in the auditorium of the Health Unit.

At the business session elections for the new year were held. Doctor B. Symchych was elected President; Dr. E. Barr, McCreary, Vice-President, and Dr. M. Potoski, Secretary-Treasurer.

Dr. M. Potoski was confirmed as representative to the Executive Committee of the Manitoba Medical Association.

Dr. C. W. Wiebe, Winkler, President of the Provincial Association, spoke briefly, asking for a more comprehensive discussion during the business session of such items as Manitoba Medical Service, Preventive Service, and Federal Health Insurance.

Dr. M. T. Macfarland, Executive Secretary, discussed the agreement with Workmen's Compensation Board, and mentioned plans for the Winnipeg meeting of Canadian Medical Association in June and renewal of agreement with the Cancer Relief and Research Institute.

Dr. D. A. Sherman, Winnipeg, spoke on "Recent Advances in Anaesthesia and Analgesia" illustrated by diagram and slide.

Dr. Ken Davidson, Winnipeg, spoke on "Common Skin Disorders" and presented several kodachrome slides of the conditions discussed.

The meeting concluded following a vote of thanks to the participants.

Refresher Course in Pediatrics Lectures

Department of Pediatrics, University of Manitoba

November—
- 10th—Newborns ..... Dr. Read
- 24th—Prematurity ..... Dr. Medovy

December—
- 1st—Child Behavior ..... Dr. Grant
- 8th—Growth ..... Dr. Read
- 15th—Celiac Syndrome ..... Dr. MacNeil

January—
- 12th—Meningitis ..... Dr. McLandress
- 19th—Kidney Diseases ..... Dr. Berger
- 26th—Pediatric Surgery ..... Dr. Clark

February—
- 2nd—Skin Diseases ..... Dr. Birt
- 9th—Dehydration and Parenteral Fluids ..... Dr. Read
- 16th—Convulsions ..... Dr. Israels
- 23rd—Pediatric Miscellany ..... Dr. Martin

Medical Library Evening Hours

Sponsored by the Winnipeg Medical Society

The Library will be open from 8 p.m. to 10 p.m., Monday through Friday, from November 1st to December 19th, 1952, and from January 5th to April 30th, 1953.

Regulations

(1) The Library Committee wishes it understood that the Closing Hour of 10 p.m. will be STRICTLY ADHERED TO;

(2) All Reading Room facilities available to Physicians and Students;

(3) The Student on duty will assist in looking up subjects in the Quarterly Cumulative Index Medicus for the last ten years;

(4) If previous references are required they should be obtained during the regular library hours (9 a.m. to 5.30 p.m.).

(5) **The Stackrooms will NOT BE OPEN.**

The Medical Library Committee.
September 15, 1952.

College of Physicians and Surgeons of Manitoba

Registration Committee — May 27, 1952

Enabling Certificates Deferred

Hans Hermann Klupp, M.D., U. Hamburg, 1938.
Otto Lempp, M.D., U. Kiel, 1938.
Pieter de Jong, M.D., Leiden U., 1950.
Gustaaf Adolf Mertens, M.D., Leiden U., 1950.

Enabling Certificates Granted

David Chen-Hwa Sun, M.D., St. John's U., 1946.
Daniel Shao-Fu Liang, M.D., St. John's U., 1949.

Certificates of Registration Confirmed

Evan Hugh Evans, M.R.C.S., England, 1935; L.R.C.P., London, 1935.
Davina Mouat Cowan, M.B., Ch.B., U. Edinburgh, 1941.

Certificate of Licence Granted

Thelma Winifrid Dafforn, M.R.C.S., England, 1949; L.R.C.P., London, 1949.

Dr. ....'s file was referred to the Registration Committee by Council at the meeting held May 17, 1952. Attention was drawn to the letters of April 23rd and April 28th, but no further action was taken.

Registration Committee — July 23, 1952

Enabling Certificates Deferred

King-Shue Luke, M.B., National Hsiang Ya Medical College, 1943.
Gerhard Conradi, M.D., Friedrich-Schiller U., Jena, 1942.
Wladyslaw Nakielny, M.D., U. Bern, 1951.

Enabling Certificates Granted

Kuei-en Chung, M.B., Cheeloo U., 1944.
Koon-Chock Young, M.D., National Sun Yat Sen U., 1944.
Ting Kwan Wong, M.D., West China Union U., 1950.
Edith Shu-Ai Hwang, M.D., Cheeloo U., 1938.
Mykola Kucharyszyn, M.D., U. Carl, 1929.
Wolodymyr Czubaty, M.D., U. Carl, 1929.

Certificates of Registration Confirmed

Alexander Lindsay, M.B., Ch.B., U. Glasgow, 1943; D.O.M.S., London, 1946.
Isabel Margaret Forster, L.R.C.P., Edinburgh, 1950; L.R.C.S., Edinburgh, 1950; L.R.F.P. & S., Glasgow, 1950.
Findlay Malcolm, M.B., Ch.B., U. Edinburgh, 1949.
Albert Mansfield Beach, M.D., C.M., McGill U., 1949; L.M.C.C., 1950.
Markus Scherz, M.D., U. Brussels, 1941; L.M.C.C., 1952.
Peter Suderman, M.D., Goettingen U., 1950; L.M.C.C., 1952.
Elizabeth Kolesnichenko, M.D., U. Charkow, 1941; L.M.C.C., 1952.

Certificates of Registration Granted

Richard Michael Nash, M.B., B.Ch., National U. of Ireland, 1941; F.R.C.S., England, 1951.
John Walsh, M.B., B.Ch., National U. of Ireland, 1933.
Aart Schaberg, M.D., Leiden U., 1946; L.M.C.C., 1952.
Gerard Romain Francis Landry, M.B., Laval U., 1949; M.D., Laval U., 1952; L.M.C.C., 1952.

Certificate of Registration Deferred

Louis Norman Gleeson, L.M.S.S.A., London, 1951; M.D., U. Zurich, 1952.

Certificates of Licence Confirmed

Herbert William Greenidge, M.D., C.M., Queen's U., 1945; L.M.C.C., 1945.
John David Cairns, B.M., B.Ch., U. Oxford, 1950; M.A., U. Oxford, 1950.

Certificate of Licence Granted

Griffith Hughes Devonald Evans, M.R.C.S., England, 1933; L.R.C.P., London, 1933.

The Registrar reviewed correspondence he had with the Registrar, Medical Council of Canada, concerning Dr. ...., and no action was taken.

Registration Committee — Sept. 18, 1952

1. Business Arising from Minutes of Registration Committee July 23rd, 1952.

A. Foreign Candidates Requested to Write Medical Council Examinations in Winnipeg

The Registrar pointed out that several applicants for Enabling Certificates write their Medical Council examinations in other centres, apply for registration, and are granted registration without coming to Manitoba. He inquired whether it would be advisable to have these applicants come to Manitoba to write their Medical Council of Canada examinations.

The Committee agreed that the question of requiring candidates to write their Medical Council examinations in Manitoba be brought before Executive Committee and/or Council.

B. Dr. ....

The Registrar reviewed additional correspondence with Dr. ...., and outlined two interviews he had with Dr. ....'s solicitor.

C. S/L ....

The Registrar reported he had requested the Twenty-five Dollar ($25.00) documentation fee from S/L ...., but since he was being posted overseas, he requested his Certificate of Registration be cancelled and the registration fee refunded.

The Committee agreed that the Registrar be instructed to advise S/L .... that his registration may remain in effect without payment of the documentation fee, otherwise the sum of Seventy-five Dollars ($75.00) be refunded and the

Certificate of Registration cancelled.

D. Charging Documentation Fee to Doctors With Temporary Registration

The Registrar reported that several physicians who take out a Certificate of Licence (temporary) apply for an (Enabling) Certificate to write the examinations of the Medical Council of Canada, and inquired whether a documentation fee should be charged, since the documentation fee is not charged for temporary registration, but physicians who take out permanent registration are charged.

The Committee agreed that registrants with Certificates of Licence (temporary) be charged the documentation fee when applying for an (Enabling) Certificate to write the examinations of the Medical Council of Canada.

2. Enabling Certificates Deferred

Daisy Corbin (Sih-En Feng), M.D., National Medical College of Shanghai, 1938.

Stefan Friedrich, M.D., U. Vienna, 1939.

Margaret Loewen, M.D., U. Odessa, 1939; M.D., U. Rostock, 1948.

Lorant Ferenc Kocsis, M.D., Royal Hungarian Elizabeth U., 1944.

3. Enabling Certificate Granted

Grace Chow-Wei Chen, B.M., National Tung Chi U., 1945.

4. Certificates of Registration Confirmed

Reginald Eugene Renaud, M.R.C.S., England, 1941; L.R.C.P., London, 1941.

Chien-liang Hsu, M.D., Peiping Union Medical College, 1932; L.M.C.C., 1952.

Wojciech Janusz Poznanski, M.D., U. Brussels, 1949; L.M.C.C., 1952.

Wasyl Zajcew, M.D., U. Berlin, 1943; L.M.C.C., 1952.

James Bruce Frain, M.D., U. Toronto, 1944; L.M.C.C., 1944; F.R.C.P. (C), 1951.

Edmund James Seeds Nixon Briggs, M.B., B.S., U. London, 1945; M.D., U. London, 1948; M.R.C.P., London, 1948; D.C.H., R.C.P.S., England, 1948

5. Jerzy Jozef Jan Tadeusz Klimczynski, M.B., Ch.B., Polish School of Medicine, Edinburgh, 1946; M.D., Polish School of Medicine, Edinburgh, 1949. Dr. Klimczynski has been accepted for appointment on the staff of the Hospital for Mental Diseases, Selkirk. The Committee agreed that a Certificate of Licence (temporary) be issued to Dr. Klimczynski for a period of twelve months, and he be requested to write the examinations of the Medical Council of Canada in the Spring of 1953 before permanent registration is issued.
6. Howard Alan Guest expects to graduate in medicine from Queen's University in the Spring of 1953, and inquired whether an interneship at the Manchester Memorial Hospital, Manchester, Connecticut, would be acceptable to this College. The Committee agreed that since the Manchester Memorial Hospital is approved for interneship by the American Medical Association, a year's interneship in that institution would be acceptable.
7. Murray Arthur Tanasichuk was granted a Certificate of Licence (temporary) on June 16, 1952, for use as a full time interne. Dr. Tanasichuk served as a Locum Tenens for two weeks, and inquired whether his licence would cover him during that time. The Committee agreed that Dr. Tanasichuk's Certificate of Licence would cover him during his brief employment as Locum Tenens, but suggested that a notice be addressed to each hospital, pointing out that the Certificate of Licence issued to internes during the time they are employed in a hospital should not be used as Locum Tenens, since they may become involved medico-legally.

Executive Committee

A meeting of the Executive Committee was held in the Medical Arts Club Rooms on Tuesday, September 23rd, 1952, at 8 p.m.

Present: Dr. C. B. Stewart, Chairman; Dr. Ed. Johnson, Dr. B. D. Best, Dr. C. H. A. Walton, Dr. F. K. Purdie, President ex-officio; Dr. C. E. Corrigan, Vice-President ex-officio; Dr. T. H. Williams, Treasurer ex-officio, and Dr. M. T. Macfarland, Registrar ex-officio, and Dr. C. W. Wiebe, Chairman, Legislative Committee.

1. Business Arising from Council Meeting, May 17th, 1952

A. Unregistered Physicians

The Registrar advised that the two employees of the Indian Health Services who had not been registered, had left the Province, and no further action could be taken since the time limit of twelve months had elapsed, and the Statute of Limitations was in effect.

B. Report of Legislative Committee Re Changes in Medical Act

As authorized by Council in May, Dr. C. W. Wiebe, Chairman, Legislative Committee, discussed proposed changes in the Medical Act with the Executive Committee.

Dr. Wiebe advised he had been studying the Manitoba Medical Act and comparing it with the other provincial acts. The sections 4 and 5 on medical electoral districts had been revised by Dr. J. S. Poole and amendments and by-laws accepted by Council, but the changes had not been placed before the Manitoba Legislature, and could be presented with other suggested changes by the Legislative Counsel and the Executive Committee.

The following suggestions were made for the guidance of the Legislative Committee, after consideration of Dr. Wiebe's report.

5(d), 6, etc.—agreed reference to homeopathic practitioners should not be deleted.

26-41—incorporation of interneship requirement in 31, 32, 33; and question of deleting 32(a) as suggested by Legislative Counsel.

36(1)—delete reference to ceiling, or raise amount of annual fee to "not less than five dollars and not more than ten dollars."

42-48—suggested changes by Legislative Counsel, and incorporate wording of B.C. Act. The solicitor be requested to prepare amendments to the Medical Act to replace the by-laws concerning penalties less than erasure, and suspension for members with mental diseases.

53—change wording "the right to be represented by the council" to "the right to be represented by counsel."

63-65—leave as at present.

74—leave as at present.

79—opinion of solicitor re definition of practice of medicine.

89—secure opinion of solicitor re widening this section re investments.

C. Registrars' Meeting

The Registrar reported he had attended the meeting of the Registrars which convened in Banff at the time of the C.M.A. meeting in June, and presented extracts of the minutes. The Committee agreed that the minutes should be reproduced and circulated to all members of Council, for discussion at the annual meeting.

Extracts of Minutes of Meeting of Registrars
College of Physicians and Surgeons and
Medical Boards
BANFF
12 June, 1952

Present: Dr. Lynn Gunn, Registrar, College of of Physicians and Surgeons of British Columbia. Dr. M. M. Weaver, Dean, Faculty of Medicine, University of British Columbia. Dr. Gordon G. Ferguson, Executive Secretary, Canadian Medical Association, B.C. Division (Former Registrar of the College of Physicians and Surgeons of Saskatchewan.) Dr. W. Bramley-Moore, Registrar, College of Physicians and Surgeons of Alberta. Dr. M. T. Macfarland, Registrar, College of Physicians and Surgeons of Manitoba. Dr. V. A. Snow, President, Medical Board, New Brunswick. Dr. R. T. Noble, Registrar, College of Physicians and Surgeons of Ontario. Dr. J. Fenton Argue, Registrar, Medical Council of Canada.

Standardization of Regulations for Issuing Enabling Certificates

Dr. Gunn made a presentation of suggested basic requirements for issuing of an Enabling Certificate. The following requirements were agreed upon:

A. Canadian Graduates:

1. Evidence of having completed University requirements.
2. One year internship.
3. Satisfactory evidence of good moral and professional character.

B. American Graduates:

1. Graduation from an approved medical school.
2. One year internship.
3. Satisfactory evidence of good moral and professional character.

C. British Commonwealth Graduates:

1. Graduation from a medical school approved by the General Medical Council of Great Britain.
2. Registration with the General Medical Council of Great Britain.
3. One year internship.
4. Evidence of good moral and professional character.

D. Alien Graduates:

1. Graduaion from a school as approved in the British or American Medical Directory.
2. If there is any doubt regarding the applicants qualifications, he may be required to take either:
   (a) The Provincial qualifying examinations, or
   (b) An examination in Basic Sciences.
3. Certificate of having completed 12 months internship in an approved Canadian hospital.

(It was pointed out that often the applicant becomes dissatisfied and will not complete his year's internship).

4. Satisfactory evidence of good character and professional conduct.
5. Birth Certificate and/or Passport.
6. Declaration of Intention of Canadian Citizenship, if required by Provincial Regulations.

Comments

(a) There was considerable discussion as to the need for Student Registration with a Provincial licensing body.

(b) It would appear that an effort should be made to have all Provinces require a declaration of Intention of Canadian Citizenship.

(c) Effective January 1, 1953, the General Medical Council of Great Britain will require internship before registration.

Student Registration

Some Provinces do not require medical students to be registered with the licensing body in order to be eligible for an Enabling Certificate. The opinion was expressed that there was a need for the medical schools to agree upon admission requirements.

The Chairman was requested to draw the matter to the attention of the various licensing bodies, Universities, and the Association of Canadian Medical Colleges.

Medical Council Regulations

The Chairman directed attention to the Rules and Regulations of the Medical Council of Canada passed in September, 1951. These will be reviewed at the September, 1952, meeting.

Particular attention was directed to the following:

Section 42—Any person who graduates in Medicine on or after the 1st of January, 1952, can become registered under the Canada Medical Act only

(a) by passing the examinations of the Medical Council of Canada; and

(b) upon submitting evidence that he has completed

(i) one year of satisfactory internship in a hospital or hospitals approved for internship by the licensing body of the province in which the hospital is located; or

(ii) one year of satisfactory practice under the supervision of a medical practitioner approved as a preceptor in general practice by the licensing body of the province in which he is located.

It was moved and carried that: Section 42 (b) (ii) of the new Rules and Regulations of the Medical Council of Canada, to wit, (ii) one year of satisfactory practice under the supervision of a medical practitioner approved as a preceptor in general practice by the licensing body of the province in which he is located BE DELETED.

Section 55

(a) Arrangements may be completed with any Canadian Medical School whereby the examinations of the Medical Council of Canada in whole or in part may be taken as the final examinations leading to a degree in Medicine. In such event the examinations shall first be marked by the examiners of the medical school and the papers of the candidates successful in all subjects shall be forwarded to the main board of examiners of the Medical Council of Canada in the usual manner.

(b) Candidates under Sub-Section (a) of this section whose papers are not submitted to the Main Board of Examiners of the Medical Council of Canada because of failing to be successful in all subjects shall be required to submit to examinations in all subjects either

(i) after having obtained a degree in medicine; or

(ii) as set out in sub-section (a) of this section if required to repeat the final year of their medical course.

Section 56

The examinations in whole or in part, may be taken before the period of internship when the degree in medicine is granted by the medical school prior to the period of internship.

The question of legality of the present interim certificate was raised. B.C.'s opinion was that it was not legal.

(Comment inserted by Dr. Bramley-Moore, Sept. 2, 1952: Section 47 relating to interim certificates should be re-written to cover all enabling certificate regulations).

Section 52

Re: Examination in Pathology and Bacteriology.

The dropping of this examination was considered. Several members were of the opinion that the examination should not be dropped too hastily.

Other Comments on Regulations

Dr. Bramley-Moore stated he intended recommending that when the student took his writtens before internship and his orals after, he should be advised immediately as to whether he has failed in his writtens in order that he may re-write at the time of his orals.

It was felt the Medical Council examination should be held simultaneously across Canada. This will be difficult to achieve unless the universities have a uniform starting time and time of graduation.

Licensing Fees

The following points were referred to but no recommendation made.

(a) Uniform licensing fee in Canada. Dr. Macfarland is to investigate.

(b) A fee sufficiently great to permit grants (equal to their fees) to the C.M.A. and the Divisional Associations to carry on without collecting fees themselves.

Internship—Dr. Bramley-Moore commented on the need for a review of the Internship Year.

1953 Meeting—Dr. Macfarland invited the Registrars to meet in Winnipeg in 1953.

D. Letter of Thanks From the Medical Library Committee

The Registrar presented a letter from the Chairman, Medical Library Committee, acknowledging with thanks the additional grant of Two Hundred and Fifty Dollars ($250.00), and stating that it would be of great assistance in maintaining the library up-to-date with the high costs of today.

E. Finance Committee Re Investment of College Funds

Dr. Williams advised he had looked into the matter of investing a portion of the College funds, as requested by the Council in May, and found that for $15,000.00 Dominion of Canada bonds the return at the present time would be $14,000.00, and it would take several years to make up the difference. He reported no action.

F. Number of Oral Examiners for Medical Council of Canada Examinations

It was reported that in the event of an exceptionally large number of candidates to write the examinations of the Medical Council of Canada, arrangements could be made by the representatives from the University of Manitoba and C.P. & S.

to the Medical Council of Canada, for providing extra examiners.

G. Specialist Committee

It was reported that a meeting of the Specialist Committee had been called for Sept. 24th, to consider a number of applications from members who do not hold the fellowship or certification of the Royal College of Physicians and Surgeons of Canada.

H. Dr. .....

The Registrar presented further correspondence from Dr. ....., outlined two interviews with Dr. .....'s solicitor, and was authorized to employ the College solicitor if and when the need arises.

I. University Senate

Dr. Walton reported the University Senate had made the following recommendations to the Board of Governors concerning the Basic Sciences Act:

1. That the fee paid to examiners be increased.
2. That no fee be charged to Manitoba graduates for a Certificate of Credit, but the fee for all others be increased.
3. That the examination fee be increased.

J. Manitoba Medical Register

The Registrar reported that the Medical Register had been published and a copy forwarded to each registrant in the Province.

K. Date of Council Meeting

The Committee agreed that the Council meeting should be held on Saturday, October 11th, 1952, as decided at the May Council meeting.

2. Business Arising from Registration Committee Meeting, September 18th, 1952

A. M.C.C. Candidates Required to Write Examinations in Manitoba

Dr. Walton advised there is a great number of applicants seeking Enabling Certificates to write the examinations of the Medical Council of Canada and subsequent registration in the Province, who never intend to practise in Manitoba, and who are not interviewed by the Registration Committee since arrangements are all made by mail. He considered it would be very advantageous to have the applicant come to Manitoba to write the examinations so that he could be seen in person, and also have the oral examination conducted by University of Manitoba examiners. He realized that it might prove a hardship in some cases and the rule could not be too strictly enforced.

Motion: "THAT the Executive Committee recommend to Council that candidates for the Medical Council of Canada examinations, excluding candidates registered with this College as undergraduates, who request a regular Enabling Certificate through the College of Physicians and Surgeons of Manitoba, be informed that they will be required to write their examinations in Winnipeg." Carried.

The Committee agreed that the motion should have the sanction of the Medical Council of Canada, and the Registrar was instructed to advise Dr. J. Fenton Argue of the above motion.

3. Correspondence

A. Department of National Health and Welfare, Division of Narcotic Control

The Registrar presented a secret list of persons to whom no sales of narcotics should be made from the Division of Narcotic Control, on which was the name of a Manitoba physician, and a letter from the Assistant Chief concerning another Manitoba physician.

Motion: "THAT the names of the two physicians received from the Department of National Health and Welfare, Division of Narcotic Control, be referred to the Discipline Committee." Carried.

B. Community Chest and Council of Greater Vancouver

The Registrar presented a letter and enclosed report from the Community Chest and Council of Greater Vancouver, concerning the problem of drug addiction. He stated that the Chief of the Division of Narcotic Control had discussed this matter with him on September 8th, and advised that a meeting with delegated federal officials was to be held in Vancouver to discuss the problem on an administrative level without policy decisions, and that any suggestions from this body might confuse the issues.

The Committee agreed that the letter and enclosed report should be studied by Council members before the October meeting, and directed the Registrar to reproduce them in the minutes.

COMMUNITY CHEST AND COUNCIL OF GREATER VANCOUVER

1231 Haro St.,
Vancouver 5, B.C.,
August 21, 1952.

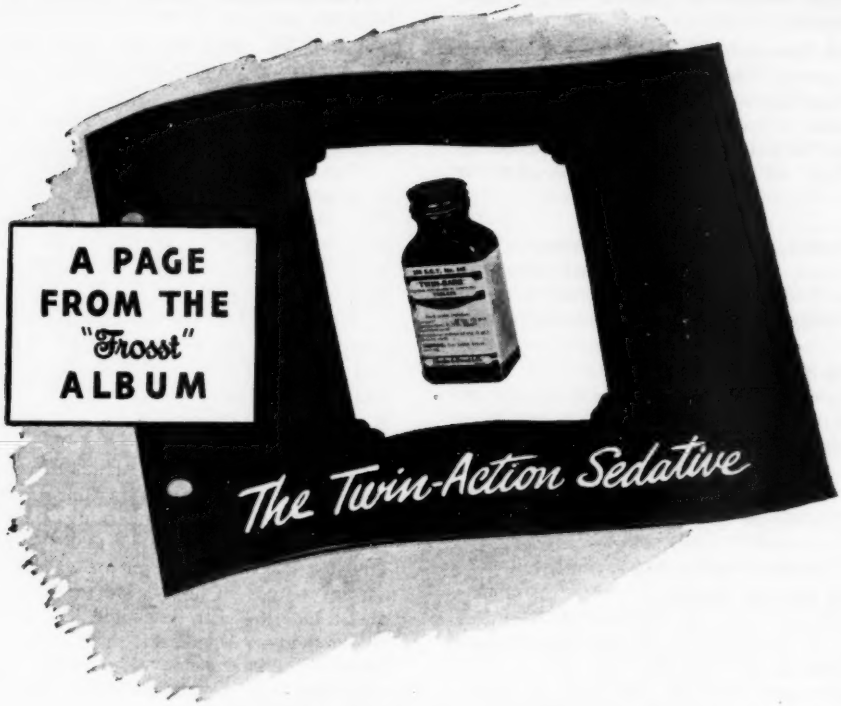
Dr. M. T. Macfarland,
College of Physicians and Surgeons
of Manitoba,
Winnipeg, Man.

Dear Dr. Macfarland:

1. Enclosed please find (a) a copy of a report of a special study committee of the Community Chest and Council of Greater Vancouver on the whole problem of drug addiction which, while having particular reference to the situation in Vancouver, is nevertheless in varying degrees applicable to other centres of population across Canada; (b) a covering letter.

2. The drug addict, in as far as his addiction is concerned, is primarily a medical problem and so the whole question should receive serious consideration from the medical profession.

3. Would you be good enough to bring this report and the covering letter before the next meeting of the Council of your College and the



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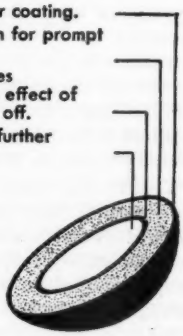

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Executive of your Division of the Canadian Medical Association where I hope it would receive serious consideration.

4. If that is done and your Council and Executive are prepared to concur in the recommendation in the report, I would hope they would be prepared to take a public stand in the matter.

5. If your Council and Executive are not prepared to concur in all the recommendations, I hope they will subject those recommendations of which they do not approve to constructive criticisms which would be forwarded to me.

6. Criticisms, suggestions and advice from such informed groups as your Council and Executive would be greatly appreciated, and if in the light of advice and suggestions received from such groups it appears that some of the recommendations should be modified or changed, that will be done.

7. We cannot stand still in this matter and have set up a strong committee to work towards a new deal in the narcotic field.

8. Copies of this report and covering letter are being sent to all Councils and the head office of the Canadian Medical Association.

Yours sincerely,
(Signed) Wallace Wilson,
Wallace Wilson, M.D.,
President.

Four months ago the Community Chest and Council of Greater Vancouver undertook an investigation of the problem of narcotic addiction in this area. A representative committee under the chairmanship of Dr. Lawrence E. Ranta, Assistant Medical Director, Vancouver General Hospital, secured all available data on this subject, analyzed it thoroughly, and prepared a report. This report, which was endorsed by the Board of Directors of the Chest and Council, was made public and has received an unusual amount of favourable comment.

The Committee's chief recommendations were:

1. The Community Chest and Council should encourage and, where necessary, sponsor and help maintain a programme of adult and youth education concerning the dangers of narcotic addiction. This programme should be carried out under the sole control of qualified experts. It should present to the public the present costs of narcotic addiction in Canada in comparison with the relatively modest cost of undertaking rehabilitation of addicts along sound lines.

2. The Provincial Government with the support of the Federal Government, as part of its health and welfare activities, should be urged to begin by establishing a pilot medical treatment and rehabilitation centre together with comprehensive follow-up services. This centre should be designed to accommodate carefully-screened volunteers in the first instance. It is felt that compulsion in the treatment of addicts has been adequately demonstrated in other countries to yield no results commensurate with the efforts expended.

It is visualized that this centre would develop into a medical rehabilitation centre to serve as a substitute for the present ineffective penitentiary confinement of addicts who have committed no crime other than becoming addicted to a narcotic drug.

3. The Federal Government should be urged to modify the Opium and Narcotic Drug Act to permit the provinces to establish narcotic clinics where registered narcotic users could receive their minimum required dosages of drug.

4. This committee feels strongly that the Federal Government should greatly increase the minimum penalties for the illegal importation, manufacture and distribution of narcotic drugs.

5. The Community Chest and Council should urge the attorney-general to implement the policy of the segregation of addicts in provincial jails. There is convincing evidence that the lack of segregation now recruits many new addicts annually in British Columbia.

The Community Chest and Council is convinced that there is urgent need for immediate and vigorous action so that these recommendations may be implemented. In order to accomplish this, your assistance is needed and requested.

A copy of the committee's full report is enclosed, and it is hoped that it may receive consideration at an early meeting of your association. If you agree with the recommendations, a formal endorsement would be of real help. All possible publicity which you can provide will facilitate our efforts.

Yours sincerely,
(Signed) Wallace Wilson,
President.

C. Dr. .....

The Registrar presented a letter from Dr. ..... reporting on the unethical procedure of a doctor from North Dakota. This doctor went to ..... to examine a patient of Dr. ....., prescribed for him, but did not consult with Dr. ..... This patient had also been seen by a doctor in Brandon who agreed with Dr. ..... diagnosis and treatment.

The Committee agreed that this should not be reported to the North Dakota State Board unless a second offence occurs, but a letter in general terms should be addressed to the doctor advising him that word has come to our attention he has been practising in the Province, and that it is considered ethical to consult with a patient's physician first.

D. General Medical Council of Great Britain Re Interneship Requirement

The Registrar presented a communication from the General Medical Council of Great Britain advising that effective January 1, 1953, one year's interneship would be required before registration on the British Register. The letter also stated that a list of approved hospitals and institutions in the British Isles was being compiled and would be available by September 30, 1952. Subsequent future editions will include overseas hospitals. The Registrar was requested to bring the communication before the Council meeting.

E. Manitoba Clinic

The Registrar presented a letter from the Manitoba Clinic with enclosed memorandum. The memorandum drawn up by the Clinic's solicitor, states that a Foundation formed as a charitable corporation would be transferred to land now being acquired from the City of Winnipeg, upon which would be erected a clinic building. A further company to be incorporated under the name of Manitoba Clinic Limited would operate the clinic and would rent the Foundation Building. The three objectives of the Clinic are:

1. To provide a fund to assist in medical education.

2. To assist in scientific research along medical lines.

2. To insure the continuation of the organization.

The Clinic inquired whether the College would give the matter consideration, and if there was any objectional feature, so advise.

Motion: "THAT in the opinion of the Executive Committee, there is no adverse criticism to the proposal of Manitoba Clinic." Carried.

4. Unfinished Business

A. Office Staff

The Registrar reported that at a meeting of the Liaison Committee—M.M.A. & C.P. & S., the following motion was passed:

"THAT the Liaison Committee recommend to the Executive Committee, College of Physicians and Surgeons, that the Manitoba Medical Association be reimbursed for the salary and unemployment insurance of Miss L. Zawadzki for the months of May to September inclusive." Carried.

Motion: "THAT the motion of the Liaison Committee concerning reimbursing the Manitoba Medical Association for salary and unemployment insurance for the months of May to September inclusive, be approved." Carried.

B. Gordon Bell Memorial

A communication was received from Dr. Colin Ferguson, present recipient of the Gordon Bell Fellowship, enclosing copies of the reports of the Ward Surgical Service at the Boston Children's Hospital during the first two months of his position as Surgical Resident. Dr. Ferguson also advised that in August, a paper entitled "Abdominal Incisions in Infants and Children—A Study of Evisceration," written by Dr. Robert Gross and himself, was submitted to Annals of Surgery for publication. A footnote acknowledged that Dr. Ferguson was the Gordon Bell Memorial Fellow from Manitoba, Canada.

The Registrar was directed to pass this information to the Trustees of the Gordon Bell Memorial.

C. University of Manitoba, Re Personal Interviews of Candidates for Admission to Medicine

The Registrar presented a further communication from the Registrar, University of Manitoba, advising that the Committee of Selection in Medicine had met on June 17th, 1952, and considered the motion of Council that individual interviews are desirable and recommended that they be brought into effect as soon as could be arranged.

The Committee concluded that:

1. Inasmuch as the interview technique is subjective, it would be difficult to defend if challenged;

2. There is no conclusive evidence that it can be classified as an objective test;

3. It would be difficult to arrange because less than 2/3 of the number of applicants would likely be available for interviews in Winnipeg.

Members of the Committee unanimously declared that it is preferable to accept as many academically qualified students as possible into the first year in Medicine, and by means of tests, interviews, observations and examinations, to weed out, at the end of the first year, those who do not give promise of success.

D. General Medical Council of Great Britain Re Chinese Applicants

A further communication was received from the Registrar, General Medical Council of Great Britain, acknowledging the information about the procedure the C.P. & S. of Mantoba has adopted in dealing with applications for Enabling Certificates from Chinese graduates. He advised he had met with Dr. K. C. Yeo, Director of Medical Services of Hong Kong, who was visiting in London, and was satisfied with the course which Manitoba and the authorities of other Canadian provinces had taken in the matter.

5. New Business

A. M.M.A. Meeting—C.P. & S. Report to Business Meeting, Thursday, October 9th, 1952

The Registrar advised that a suggestion had come to him that a report by the C.P. & S. should be given during the business meeting of the M.M.A. Convention, as had been done in previous years. The Committee considered that since the minutes of the C.P. & S. were published in the Medical Review, it would not be necessary to give a report

to the Manitoba Medical business meeting.

B. Additional Coverage on Bond

The Registrar advised he had made inquiries concerning additional coverage on the Fidelity Bond held by the C.P. & S. The Registrar is to remain at One Thousand Dollars ($1,000.00), the Treasurer to be increased from Two Thousand Dollars ($2,000.00) to Five Thousand Dollars ($5,000.00), and the assistant to the Registrar to be covered for One Thousand Dollars ($1,000.00). The additional premium on these changes amounted to Seven Dollars and Sixty Cents ($7.60).

Motion: "THAT the additional premium of Seven Dollars and Sixty Cents ($7.60) be paid on Fidelity Bond No. 1499370, to cover the changes outlined by the Registrar." Carried.

Specialist Committee

The second meeting of the College of Physicians and Surgeons Committee to set up a Specialist Register was held at 1 p.m., in the Medical Arts Club Rooms, on Wednesday, Sept. 24th, 1952.

Present were: Doctors C. H. A. Walton, Chairman, and F. K. Purdie, C.P. & S.; Doctors M. R. MacCharles and F. G. Allison, M.M.A.; Doctors B. D. Best and N. L. Elvin, Faculty of Medicine, U. of Man.; Dr. M. T. Macfarland, Registrar, ex-officio, and Dr. C. E. Corrigan, Vice-President, C.P. & S., ex-officio.

The Chairman advised that the purpose of the meeting was to consider a number of applications from registrants who do not hold the fellowship or certificate of the Royal College of Physicians and Surgeons of Canada. He further advised that after January 1, 1954, only those with Royal College standing would be considered, but in the meantime this Committee had to decide whether these applicants' training was equivalent. He read out the names of 38 members whose names have been entered on the Specialist Registrar.

The following were granted specialist registration: Doctors Maxwell Lerner, Jeffrey Emmanuel Morris, Keith Gordon Grant, Simon Witt, Chien-Liang Hsu.

The following were deferred pending receipt of additional information: Doctors Leon Aaron Pauls, Edward Gray Brownell, Ian Selkirk Maclean, Alexander Percy Guttman, Peter Berbrayer, William Emmet Dwyer.

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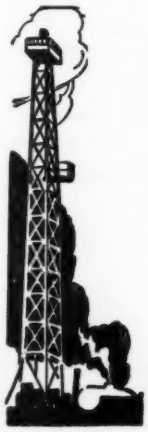

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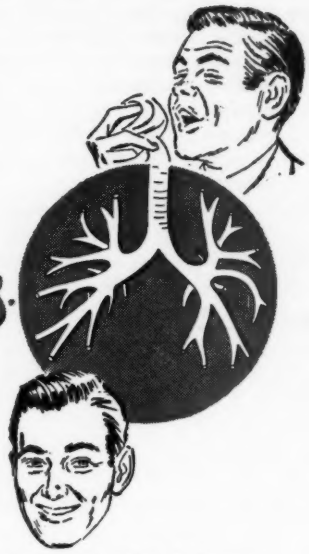

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Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1952 Nov. 2 to Nov. 29,'52	1952 Oct. 5 to Nov. 1,'52	1951 Nov. 4 to Dec. 1,'51	1951 Oct. 7 to Nov. 3,'51	Total Jan. 1 to Nov. 29,'52	Total Jan. 1 to Dec. 1,'51
Anterior Poliomyelitis	89	168	3	10	757	51
Chickenpox	192	136	231	133	1328	1625
Diphtheria	0	0	1	0	2	6
Diarrhoea and Enteritis, under 1 yr.	14	13	12	10	141	163
Diphtheria Carriers	0	0	0	0	0	1
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	4	7	0	1	25	25
Erysipelas	2	1	4	0	15	31
Encephalitis	0	1	0	0	5	4
Influenza	6	10	8	2	146	787
Measles	388	145	93	70	1694	2978
Measles—German	1	0	2	4	14	44
Meningococcal Meningitis	2	1	1	5	15	38
Mumps	137	63	145	223	1289	1512
Ophthalmia Neonatorum	0	0	2	0	1	4
Puerperal Fever	0	1	0	0	2	1
Scarlet Fever	46	24	94	112	603	1247
Septic Sore Throat	4	3	14	2	75	43
Smallpox	0	0	0	0	0	0
Tetanus	0	1	0	0	4	1
Trachoma	0	0	0	0	0	0
Tuberculosis	101	69	83	79	812	1003
Typhoid Fever	0	0	2	1	5	5
Typhoid Paratyphoid	0	0	0	0	2	0
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	1	0	1	0	5	12
Whooping Cough	14	12	84	109	406	678
Gonorrhoea	82	87	109	90	1200	1161
Syphilis	9	6	11	8	104	155
Infectious Jaundice	26	5	0	0	60	0
Tularemia	0	0	0	0	4	0

Four-Week Period November 2nd to November 29th, 1952

DISEASES (White Cases Only) *Approximate population.	*776,541 Manitoba	*861,600 Saskatchewan	*3,825,000 Ontario	*2,983,000 Minnesota
Anterior Poliomyelitis	89	82	**25	294
Chickenpox	192	179	1226	—
Diarrhoea & Enteritis, under 1 year	14	13	—	—
Diphtheria	—	—	3	1
Diphtheria Carriers	—	—	—	—
Dysentery—Amoebic	—	—	—	5
Bacillary	4	1	16	57
Encephalitis Epidemica	—	—	—	—
Erysipelas	2	1	—	—
Influenza	6	—	11	7
Infectious Jaundice	26	30	32	31
Measles	388	227	523	519
German Measles	—	5	55	—
Meningitis Meningococcus	2	3	14	3
Mumps	137	52	885	—
Ophthal. Neonat.	—	—	—	—
Puerperal Fever	—	—	—	—
Scarlet Fever	46	66	166	131
Septic Sore Throat	4	8	3	12
Smallpox	—	—	—	—
Tetanus	—	—	—	—
Trachoma	—	—	—	—
Tularemia	—	—	—	—
Tuberculosis	101	28	79	168
Typhoid Fever	—	—	3	1
Typh. Para.-Typhoid	—	1	—	—
Typhoid Carrier	—	—	—	—
Undulant Fever	1	—	1	—
Whooping Cough	14	59	106	4
Gonorrhoea	82	—	119	—
Syphilis	9	—	44	—
Malaria	—	—	—	3

**Ontario figures for three weeks only.

DEATHS FROM REPORTABLE DISEASES

For the Month of November, 1952

Urban — Cancer, 57; Pneumonia Lobar (490) (491-493), 2; Pneumonia (other forms), 9; Pneumonia of Newborn (763), 1; Poliomyelitis, 3; Tuberculosis, 4; Diarrhoea & Enteritis (under 2 years) (053), 1; Septicaemia & Pyaemia (053), 1; Benign Neoplasms (210-229), 1. Other deaths under 1 year, 22. Other deaths over 1 year, 211. Stillbirths, 24. Total, 257.

Rural — Cancer, 29; Influenza, 1; Measles, 4; Pneumonia Lobar (490) (491-493), 1; Pneumonia (other forms), 12; Pneumonia of Newborn (763), 1; Tuberculosis, 3; Diarrhoea & Enteritis (under 2 years) (053), 4; Benign Neoplasms (210-229), 1. Other deaths under 1 year, 17. Other deaths over 1 year, 198. Stillbirths, 8. Total, 223.

Indians—Influenza, 1; Measles, 1; Pneumonia (other forms), 1; Dysentery (048), 1; Diarrhoea & Enteritis (under 2 years) (053), 1. Other deaths under 1 year, 1. Other deaths over 1 year, 5. Stillbirths, 1. Total, 7.

♦

Poliomyelitis is at last over for 1952. A few cases may still be late reported, and the odd death as several cases are still in respirators. At date of writing (December 8th) 761 cases have been reported with 25 deaths. Slightly over one half showed some paralysis (413) but many of these have now made complete recovery and many more will but quite a number will require prolonged treatment and some will have permanent disability. The Department wishes to thank all the doctors who have reported cases, filled in forms giving us needed information, etc.

We also wish you a Merry Christmas and a Happy New Year.

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